



NHS Pay Review Body

Twenty-Sixth Report 2012

Chair: Jerry Cope



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**Presented to Parliament by the
Prime Minister and the Secretary of State for Health**

**Presented to the Scottish Parliament by the
First Minister and the Cabinet Secretary for Health, Wellbeing
and Cities Strategy**

**Presented to the National Assembly for Wales by the
First Minister and the Minister for Health and Social Services**

**Presented to the Northern Ireland Assembly by the First Minister,
Deputy First Minister and the Minister for Health, Social Services
& Public Safety**

**By Command of Her Majesty
March 2012**

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NHS Pay Review Body

The NHS Pay Review Body (NHSPRB) is independent. Its role is to make recommendations to the Prime Minister, the Secretary of State for Health, the First Minister and the Cabinet Secretary for Health and Wellbeing in Scotland, the First Minister and the Minister for Health and Social Services in the National Assembly for Wales, and the First Minister, Deputy First Minister and Minister for Health, Social Services and Public Safety of the Northern Ireland Executive, on the remuneration of all staff paid under Agenda for Change (AfC) and employed in the National Health Service (NHS)*.

In reaching its recommendations, the Review Body is to have regard to the following considerations:

- the need to recruit, retain and motivate suitably able and qualified staff;
- regional/local variations in labour markets and their effects on the recruitment and retention of staff;
- the funds available to the Health Departments, as set out in the Government's Departmental Expenditure Limits;
- the Government's inflation target;
- the principle of equal pay for work of equal value in the NHS;
- the overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved.

The Review Body may also be asked to consider other specific issues.

The Review Body is also required to take careful account of the economic and other evidence submitted by the Government, Trades Unions, representatives of NHS employers and others.

The Review Body should take account of the legal obligations on the NHS, including anti-discrimination legislation regarding age, gender, race, sexual orientation, religion and belief, and disability.

Reports and recommendations should be submitted jointly to the Prime Minister, the Secretary of State for Health, the First Minister and the Cabinet Secretary for Health and Wellbeing in Scotland, the First Minister and the Minister for Health and Social Services of the National Assembly for Wales, and the First Minister, Deputy First Minister and Minister for Health, Social Services and Public Safety of the Northern Ireland Executive.

* References to the NHS should be read as including all staff on AfC in personal and social care service organisations in Northern Ireland.

Members of the Review Body are:

- Mr Jerry Cope (Chair)
- Mr Philip Ashmore
- Professor David Blackaby
- Dame Denise Holt
- Mr Graham Jagger
- Mr Ian McKay
- Mrs Maureen Scott
- Professor Anna Vignoles

The secretariat is provided by the Office of Manpower Economics.

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Summary of Recommendation and Main Conclusions

Our remit for 2012/13 continues to be constrained by the UK Government's and Devolved Administrations' public sector pay policies. The second year of the Governments' public sector pay policies is the same as the first year in that it narrows our remit to consideration of pay recommendations for NHS Agenda for Change (AfC) staff earning £21,000 or less and any cases presented to us regarding high cost area supplements (HCAS) and recruitment and retention premia (RRP). We also consider the evidence against our standing terms of reference.

We welcome that the four Governments value the independent and expert view that the Review Bodies provide. Against the background of the constrained remit, we reiterate: the importance of the independent process; our ability to consider the full range of evidence on pay and related matters under our terms of reference; and our role in making independent recommendations to the four Governments. We consider that these are particularly important in maintaining the confidence of Agenda for Change staff.

We note major developments on the proposed NHS reforms and on changes to public sector pensions. We intend to keep these under review and assess how they impact on the recruitment and retention and morale and motivation of the NHS workforce for our next pay round.

AfC Staff Earning £21,000 or Less

We acknowledge that the £250 increase and its application to those earning £21,000 or less were matters of judgement for the UK Government and the Devolved Administrations. We make our assessment of the level of uplift against the four factors we were invited to consider by the Chief Secretary to the Treasury. First, on the level of progression pay provided to the workforce, we have commented in previous reports that incremental progression is a separate issue to basic pay and that continues to be our position. Around two-thirds of AfC staff earning £21,000 or less had not reached the top of their pay bands and would therefore be entitled to receive incremental progression of between 1.8% and 3.7%. Also the Department of Health's interim findings from its new approach suggested overall pay drift in the order of 0.5% to 0.75% in 2009/10 and 2010/11 for Hospital and Community Health Services – the reduction in estimated pay drift from the old approach largely reflects the use of average workforce levels over the year.

Second, on affordability we note that the NHS in England received a "better" Spending Review settlement than many other parts of the public sector although available NHS funding was extremely tight. The Devolved Administrations also face cost pressures and the need to achieve efficiency savings. We accept that affordability of pay awards is impacted by growing underlying demand for services, costs associated with service developments and the need to achieve significant efficiency savings of up to £20 billion by 2014/15 (including by controlling pay bills). Third, on the potential for payments to be more generous for those on the lowest earnings, we have received no evidence to support any differentiation including UNISON's proposal to bring the minimum wage in the NHS in line with the Rowntree Foundation Minimum Income Standard. Fourth, on how best to avoid "leapfrogging" of those earning just under £21,000 with those earning just over, we note that a £250 increase would not produce any overlap between AfC pay points but we ask the parties to discuss the narrowing of the differential between AfC pay points 15 and 16, should our recommendation be accepted and implemented, in time for our next pay round.

In addition to the four factors in the Chief Secretary to the Treasury's letter, we also assessed the uplift against the relevant remaining factors in our standing terms of reference. From the available evidence, we continue to conclude that overall for AfC staff recruitment is healthy and retention remains stable. However, NHS recruitment and retention must be seen in the light of prevailing economic circumstances – there have been: downgraded economic expectations for 2012; reductions in public sector employment; and increases in unemployment to its highest

level since August 1994. We have commented before that we have sympathy with the Staff Side's argument on the impact of the recent period of high inflation rates, particularly on the lower paid, and that staff have had a reduction in real wages. However, this concern is not unique to NHS staff. Our recommendations are not linked to inflation as it is only one of a range of our considerations. Finally, we note the concerns over a range of influences on morale and motivation including budget reductions, job security, impacts on workloads from vacancy freezes or delayed recruitment, service reconfigurations and workforce restructuring, pension changes and the NHS reforms in England.

Judged against all the required factors, our overall assessment is that there is no case to justify any increase above a flat rate £250 for those AfC staff earning £21,000 or less. **We recommend an uplift of £250 to Agenda for Change spine points 1 to 15 from 1 April 2012.**

High Cost Area Supplements (HCAS) and National Recruitment and Retention Premia (RRP)

We received no proposals or evidence on existing high cost area supplements or proposals for supplements for new areas.

On the issue of a national RRP for pharmacists, our assessment from the evidence is that any remaining recruitment and retention issues exist only in specific localities and we would encourage employers to use local RRP where these are supported by appropriate evidence. In the light of the latest survey evidence, our specific review of the position on pharmacists is no longer required but we ask that the parties draw our attention to evidence on the vacancy situation as appropriate.

We consider UCATT's case for a new national RRP for building craft workers is again unconvincing. We strongly recommend if UCATT pursues this issue it bears in mind that RRP are for situations where market pressures would otherwise prevent the employer from being able to recruit and retain staff in sufficient numbers. UCATT has failed to present robust and relevant evidence that shows there are widespread recruitment and retention difficulties applying to NHS building craft workers.

We note the Royal College of Midwives' concerns about the shortages of newly qualified midwives and keeping the need for a national RRP under review. We consider this an issue largely of supply and conclude that further action is needed to manage more effectively workforce and training planning to ensure an adequate supply of midwives in the right locations.

General Workforce Issues

Our remit also allowed us to consider information about recruitment, retention and other aspects of the NHS workforce for those paid above £21,000. We note that falls in the number of NHS training commissions can store up potential manpower supply problems and ask the parties to report any concerns in future evidence. On AfC shortage groups, we note that the position might be easing slightly although further monitoring is required. We ask that the parties keep us informed of any pay and workforce issues for shortage groups. It is clear that morale and motivation across the NHS workforce is threatened by a variety of local pressures and national developments. They could present significant challenges to employers in meeting demand for quality services and delivering on the wide-ranging change agenda, plus they could threaten longer term recruitment and retention.

On workforce planning, we welcome the new role of the Centre for Workforce Intelligence but are concerned whether local healthcare providers can give sufficient priority to deliver effective local workforce planning. We also remain concerned about the accountability and responsibility for education and training provision as they become localised thereby risking the appropriate level of investment and activity. Our view is that the use of the Knowledge and

Skills Framework remains patchy but can yield positive results where fully implemented. On our data requirements, the absence and inconsistency of NHS workforce data risk undermining our pay recommendations and addressing these will become increasingly important to our future remits.

A Forward Look

We report on the Chancellor's announcement on our remits during 2012 to consider how to make pay more market-facing in local areas for NHS AfC staff and that, for the two years following the end of the pay freeze, the Government will seek public sector pay awards that average 1%. We consider briefly a range of issues in the light of our forthcoming remits including the public sector pay freeze, AfC flexibilities, public sector pensions, staff engagement, and our data and evidence requirements. We conclude by commenting on the constraints placed on our remit including our concern that they do not allow us to consider the full range of evidence and issues. We believe that the Review Body process adds most value when it is able to bring independent and expert judgment to bear on all factors within our terms of reference – including the Government's economic and affordability evidence – while maintaining the trust of all parties to do so. Our terms of reference already allow the Government to ask us to consider any other specific issues. The ability to make independent judgments ensures that we maintain the confidence of NHS Employers and the Staff Side in the process.

MR JERRY COPE (*Chair*)

MR PHILIP ASHMORE

PROFESSOR DAVID BLACKABY

DAME DENISE HOLT

MR GRAHAM JAGGER

MR IAN MCKAY

MRS MAUREEN SCOTT

PROFESSOR ANNA VIGNOLES

3 February 2012

Chapter 1 – Introduction and Background

Introduction

- 1.1 Our remit for 2012/13 continues to be constrained by the UK Government's and Devolved Administrations' public sector pay policies. The second year of the Governments' public sector pay policies is the same as the first in that it narrows our remit to consideration of pay recommendations for NHS Agenda for Change (AfC) staff earning £21,000 or less and any cases presented on high cost area supplements (HCAS) and recruitment and retention premia (RRP). We consider the evidence against this remit and also with reference to our standing terms of reference as set out at the front of this report.
- 1.2 The detailed remit for 2012/13 was set out in letters from the Chief Secretary to the Treasury, the Secretary of State for Health and the Ministers in the Devolved Administrations. This report examines the evidence presented by the parties on the specific requirement to consider AfC staff paid £21,000 or less and the pay proposals made by the parties. Our remit also allowed us to consider information about recruitment, retention and other aspects of the NHS workforce for those paid above £21,000.

Twenty-Fifth Report 2011¹

- 1.3 We submitted our Twenty-Fifth Report on 11 March 2011 to the Prime Minister, Secretary of State for Health and the relevant Ministers for the Devolved Administrations. Our report was made in the context of the first year of the UK Government's and Devolved Administrations' policies of a public sector pay freeze for those earning more than £21,000. Within this constrained remit, we recommended an uplift of £250 to AfC spine points 1 to 15 from 1 April 2011. On 21 March 2011, the UK Government announced its acceptance of our recommendations and conclusions in full². Shortly afterwards, the Devolved Administrations also confirmed their acceptance of our report.

Remit for our Twenty-Sixth Report

- 1.4 We set out the background to the UK Government's and Devolved Administrations' approach to public sector pay in our Twenty-Fifth Report³ covering the context of the Coalition Government's programme for government, the Spending Review 2010 and the detail of our remit for the first year of the public sector pay policies.
- 1.5 The second year of the four Governments' policies determined our remit for this pay round. The Chief Secretary to the Treasury wrote to all Review Body Chairs on 20 June 2011 setting out how the UK Government proposed that the Review Bodies should approach the round. The UK Government continued to consider that the case for pay restraint across the public sector remained strong. The Chief Secretary to the Treasury added that at the highest level, while the UK Government recognised some variation between remit groups, it considered there were unlikely to be significant recruitment and retention issues for the majority of public sector workers over the next year. With regard to affordability, the UK Government considered pay restraint remained a crucial part of the consolidation plans helping to put the UK back onto the path of fiscal sustainability.
- 1.6 The letter outlined the UK Government's view that this pay round should proceed in line with that for 2011/12 with the Review Bodies making recommendations in relation to those workers earning £21,000 or less. The Chief Secretary to the Treasury defined

¹ NHSPRB (2011), *Twenty-Fifth Report*, TSO (Cm 8029).

² Written Ministerial Statement, Secretary of State for Health, 21 March 2011 (Hansard Column 43WS).

³ NHSPRB (2011), *Twenty-Fifth Report*, TSO (Cm 8029), paragraphs 1.4 – 1.10.

this as basic salary of a full time equivalent employee not including overtime or any regular payments such as London weighting, recruitment and retention premia or other allowances. Review Bodies were invited to consider the size of the uplift for those earning £21,000 or less with the Government seeking an uplift of at least £250. In doing so, Review Bodies may want to consider progression pay, affordability, the potential for payments to be more generous for those on the lowest earnings, and how best to avoid “leapfrogging” of those earning just under £21,000 with those earning just over £21,000.

- 1.7 The Chief Secretary to the Treasury’s letter added that the UK Government had accepted the recommendations of Lord Hutton’s report on the future of public sector pensions⁴ (see also paragraphs 1.23 to 1.24) as a basis for consultation on this issue. These included a recommendation that the UK Government make clear to Review Bodies that they should consider how public service pensions affect total reward and the UK Government would return to this issue in advance of the 2013/14 round. However, the UK Government’s view was that any changes to pensions, including the proposed increase in contributions from 2012/13, did not justify upwards pressure on pay.
- 1.8 The Secretary of State for Health confirmed the remit in a letter to us on 22 August 2011. He added that the Department of Health would submit evidence to support the process including, as necessary, evidence on high cost area supplements, recruitment and retention premia, and information on other aspects for those earning more than £21,000.
- 1.9 The Minister for Health and Social Services in the Welsh Government wrote to us on 18 September 2011 confirming the same remit as the Chief Secretary to the Treasury had outlined and confirming the provision of evidence, as necessary.
- 1.10 The Minister for Health, Social Services and Public Safety in Northern Ireland wrote on 27 September 2011 confirming that the two-year pay freeze for public sector workers would apply in 2012/13 but recognising that there would be an increase of at least £250 for Health and Social Care staff earning £21,000 or less subject to the Review Body process in the usual way.
- 1.11 The Deputy First Minister and Cabinet Secretary for Health, Wellbeing and Cities Strategy in the Scottish Government also wrote to us on 30 September 2011 confirming Scotland’s public sector pay policy including: a pay freeze for all staff except those earning £21,000 and below; supporting lower paid staff by uprating the Scottish Living Wage to £7.20 per hour from 1 April 2012; and a commitment that all staff earning less than £21,000 should receive a minimum annual pay increase of £250. The Scottish Government sought recommendations from us on uplifts within the parameters of its public sector pay policy.
- 1.12 The remit letters from the UK Government and each of the Devolved Administrations are at Appendix A.
- 1.13 We commented in our Twenty-Fifth Report⁵ on the constraints placed on our deliberations by the four Governments’ approaches to public sector pay. While we are aware of the economic circumstances and the four Governments’ approaches to managing public finances, we have experienced a significant period where our ability to consider our full terms of reference has been limited. Following the end of the UK Government’s policy of a public sector pay freeze, the Chancellor has announced that there will be a further period of public sector pay restraint in 2013/14 and 2014/15 (see Chapter 6). We welcome the Chief Secretary to the Treasury’s acknowledgement

⁴ Independent Public Service Pension Commission: Final Report (10 March 2011). Available at: www.hm-treasury.gov.uk/pensionscommission.

⁵ NHSPRB (2011), *Twenty-Fifth Report*, TSO (Cm 8029), paragraph 1.11.

in his 20 June 2011 letter that the Government greatly values the independent and expert view that the Review Bodies provide. Against this background, we reiterate the importance of our independent process, our ability to consider the full range of evidence on pay and related matters under our standing terms of reference, and our role in making independent recommendations to the four Governments. These are particularly important in maintaining confidence in the Review Body process among Agenda for Change staff.

Parties Giving Evidence for our Twenty-Sixth Report

1.14 Our schedule for this review was established to enable us to deliver our report by February 2012. We can only produce timely reports if the parties deliver written evidence to our schedule. In this respect, NHS Employers, the Joint Staff Side and individual unions met our deadline for submission of evidence although we were disappointed that the Department of Health and Devolved Administrations delayed their evidence. Our remits during 2012 (see Chapter 6) will involve particularly challenging work programmes and we, therefore, remind the Health Departments of the importance of timely submission of evidence.

1.15 We received written evidence from the following organisations for this report:

Government departments

Department of Health (DH), England;
Department of Health, Social Services and Children (DHSSC), Wales;
Department of Health, Social Services and Public Safety (DHSSPS), Northern Ireland;
Scottish Government Health and Social Care Directorates (SGHSCD);

Bodies representing NHS staff

Joint Staff Side⁶;
British and Irish Orthoptic Society (BIOS);
Royal College of Midwives (RCM);
Royal College of Nursing (RCN);
UNISON;
Unite the Union;
Union of Construction, Allied Trades and Technicians (UCATT);

Employers' bodies

NHS Employers.

1.16 Following consideration of the written evidence, we held four separate oral evidence sessions in November 2011 with: the Secretary of State for Health, HM Treasury and the four Health Departments' officials; NHS Employers; the Joint Staff Side; and UCATT. Our programme included 11 Review Body meetings in which we considered the evidence, supporting information on the economy and labour market, and our conclusions and recommendations. We would like to thank the parties for submitting written evidence and attending our sessions.

⁶ The Joint Staff Side comprises: British Association of Occupational Therapists; British Dietetic Association; British Orthoptic Society; Chartered Society of Physiotherapists; Federation of Clinical Scientists; GMB; Royal College of Midwives; Royal College of Nursing; Society of Chiropractors and Podiatrists; Society of Radiographers; UCATT; UNISON; and Unite.

Review Body Visits in 2011

1.17 Our visits are an essential supplement to the parties' evidence. We aim to visit a range of NHS organisations to meet and discuss issues with members of our remit group and NHS management. We would like to thank all those who gave their time to meet with us and those organising our visits.

1.18 Between April and July 2011 we visited the following NHS organisations:

England

- Cambridge University Hospitals NHS Foundation Trust;
- NHS North of Tyne;
- Northumbria Healthcare NHS Foundation Trust;
- North East Ambulance Service NHS Trust;
- South London Healthcare NHS Trust;
- Maidstone and Tunbridge Wells NHS Trust;

Scotland

- NHS Tayside;

Wales

- Hwyl Dda Health Board;

Northern Ireland

- Western Health and Social Care Trust.

Other Developments

1.19 We summarise below two developments which provide background to our considerations this year: the proposed NHS reforms and changes to public sector pensions. These will begin to take effect from our next pay round and therefore we intend to keep them under review, and assess how they impact on the recruitment and retention and morale and motivation of the NHS workforce.

NHS Reforms

1.20 The UK Government's proposed NHS reforms in England were set out in the *Health and Social Care Bill*⁷ presented to Parliament on 19 January 2011. The Bill contained five themes: strengthening commissioning of NHS services; increasing accountability and public voice; liberating provision of NHS services; strengthening public health services; and reforming health and care arms length bodies. In April 2011, the UK Government decided to "pause, listen and reflect" on the content of the Bill. It established the NHS Future Forum⁸ as an independent group to consult on the Bill's themes. The Forum initially focussed on four core themes: choice and competition; public accountability and patient involvement; clinical advice and leadership; and education and training. The Forum made a series of recommendations on these themes and the UK Government accepted the core recommendations on 14 June 2011⁹ and agreed to make improvements to its modernisation plans including amendments to the *Health and Social Care Bill*. All statutory changes due in April 2012 would not now happen before July 2012.

⁷ Available at: <http://services.parliament.uk/bills/2010-11/healthandsocialcare.html>.

⁸ The NHS Future Forum comprised a group of 45 senior professionals from across health and social care which attended around 250 events, heard from over 8,000 people including 250 stakeholder organisations. Full report available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127443.

⁹ Written Ministerial Statement, Secretary of State for Health, 14 June 2011.

- 1.21 At the time of submission of this report, the *Health and Social Care Bill* had passed through the committee stage in the House of Lords and will move to the report stage on 8 February 2012.
- 1.22 NHS Employers commented in written evidence that the reforms in England were the most significant reorganisation of the NHS in its history with major implications for the workforce. The Staff Side noted that the Bill would radically alter the way the NHS in England was run, funded and held accountable. Individual Staff Side unions expressed strong concerns about the Bill. They signalled their opposition to the promotion of competition over cooperation and opposition to provisions to encourage local commissioning consortia and foundation trusts to enter into local pay bargaining. The Staff Side believed that this would break down the national pay agreement resulting in fragmented, inconsistent systems which would be locally costly to develop and would result in industrial instability. The Staff Side also provided a paper¹⁰ which they said supported their view that national pay determination was essential for fair pay for NHS staff and provided industrial stability, prevented unequal pay problems, and aided NHS recruitment and retention.

Public Sector Pensions

- 1.23 At the time we submitted our Twenty-Fifth Report, the final report of the *Independent Public Service Pensions Commission*¹¹, led by Lord Hutton, was published on 10 March 2011. The main recommendations were: a switch from final salary to career average pension schemes for all public service employees; and an alignment of the Normal Pension Age in these schemes with the State Pension Age. The Commission added that it was for the Government to make difficult decisions on the key parameters of the pension schemes including accrual rates, indexation levels and employee contributions. The Commission recommended that public service employers take greater account of public service pensions when constructing remuneration packages and designing workforce strategies.
- 1.24 The Budget on 23 March 2011 included the UK Government's acceptance of Lord Hutton's recommendations as a basis for consultation with public sector workers, trade unions and others and that it would set out proposals in the autumn that were affordable, sustainable and fair to both the public sector workforce and the taxpayer. On 19 July 2011, the Chief Secretary to the Treasury announced that the UK Government and the Trades Union Congress had held meetings to discuss public service pension reform with scheme level discussions planned to deliver initial proposals for reformed schemes by the end of October 2011 within the UK Government's parameters for scheme design. The UK Government was committed to secure spending review savings of £2.3 billion in 2013/14 and £2.8 billion in 2014/15 requiring each scheme to find savings equivalent to a 3.2 percentage point increase.
- 1.25 On 28 July 2011, the Department of Health and Welsh Government published a consultation on proposed changes to the level of contributions made by NHS Pension Scheme members for 2012/13 only. The Department of Health responded to the consultation on 8 December 2011 and modified its original proposal based on recommendations from NHS Employers supported by the Association of UK University Hospitals. The modifications included: the distribution of employee contribution increases for 2012/13 should be presented net of tax relief to reflect the actual burden on scheme members; further contribution increases for those in full time salary bands from £26,558 to £48,982 and from £48,983 to £69,931; and the savings yielded to be redistributed so

¹⁰ *National Pay Determination in the NHS: Resilience and Continuity* – Ian Kessler, Reader in Employment Relations at the Said Business School and Fellow at Green Templeton College, University of Oxford.

¹¹ Independent Public Service Pensions Commission: Final Report (10 March 2011). Available at: www.hm-treasury.gov.uk/pensionscommission.

as to remove the need for a contribution increase for members earning up to £26,557. The Department stated that these modifications would achieve the required cost savings within the UK Government's preferred scheme design parameters. Continuing discussions with trade unions were planned on contribution rates for 2013/14 and 2014/15 and longer term reforms to pension schemes from April 2015.

- 1.26 On 20 December 2011, the Secretary of State announced¹² the heads of agreement following discussion with NHS trade unions and employers. It set out the UK Government's final position on the NHS Pension Scheme design from 2015 and included the level of member contributions for 2012/13. At the time of submission of this report, individual NHS trade unions were considering their responses to the UK Government's final position.
- 1.27 On public service pensions more generally, the UK Government announced on 2 November 2011 the detail of its "offer" to public sector workers to come into force in 2015. The "offer" included a more generous accrual rate from 1/65ths to 1/60ths and those workers within 10 years of their pension age on 1 April 2012 would be protected. The Government's proposals were conditional on agreement being reached in scheme by scheme talks.
- 1.28 In evidence for this report, the Staff Side expressed concern about the Government's planned pension changes which would mean that NHS staff would work longer, pay more and get less. As staff currently paid around 6% of their total salary as pension contributions, the Staff Side considered there could be a 50% increase in contributions for a significant number and a rise of 25% even for the low paid. They viewed this as a substantial loss of earnings coming on top of the erosion in wages caused by inflation during the pay freeze. The Staff Side also pointed to a range of individual union surveys which they considered demonstrated the dangers of pension reforms, the growing sense of uncertainty and anxiety about increased contributions to the NHS scheme, the impact of contribution increases on the low paid, and the high proportions that might leave the scheme. On 30 November 2011, the Trades Union Congress held a "day of action" to reflect the concerns of trade union members over Government proposals for public sector pensions.
- 1.29 During this round, we have monitored developments in public sector pensions and specific proposals for the NHS Pension Scheme. It is clear from the Staff Side evidence that NHS staff have significant concerns over planned increases in contributions from 2012 and longer term changes from 2015. Such changes will impact on the "total reward package" available to NHS staff and might influence recruitment, retention and motivation. We comment briefly in Chapter 6 on how these might feature in our remits during 2012.

Legal Obligations on the NHS

- 1.30 Under our standing terms of reference we are required to take account of legal obligations on the NHS including anti-discrimination legislation. During our oral evidence sessions, the parties confirmed that there were no specific issues for consideration under the remit for 2012/13. In written evidence, UNISON commented that the NHS Staff Council had reviewed and amended the NHS Terms and Conditions Handbook to ensure compliance with the *Equalities Act 2010*. The Joint Staff Side and NHS Employers also updated us on the publication of the NHS Staff Council's toolkit in March 2011 to help employers meet their obligations under equality legislation.

¹² Available at: <http://www.dh.gov.uk/health/2011/12/pensions-agreement/>.

Chapter 2 – Recruitment, Retention and Earnings of Our Remit Group

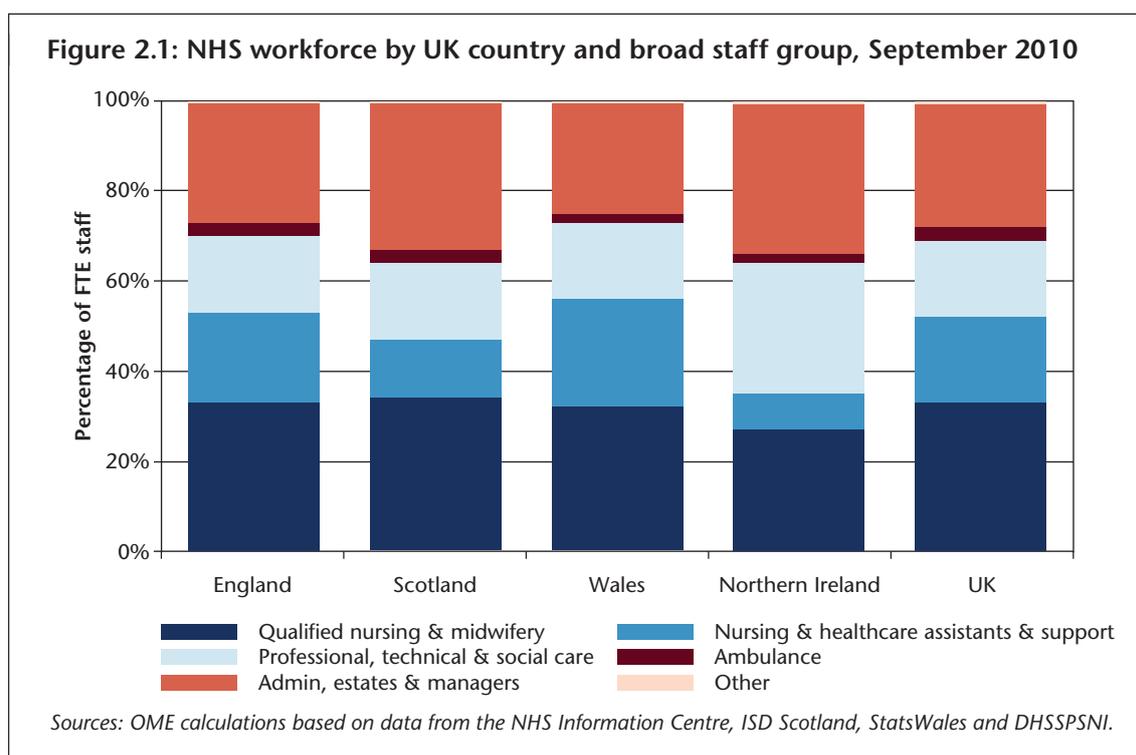
Introduction

2.1 This chapter provides summary information on: the size and composition of the NHS non-medical workforce in each UK country; recent changes in the size of the workforce; vacancies and turnover; earnings; and membership of the NHS Pension Scheme. Data relate to full time equivalent (FTE) staff except where specified.

Composition of Our Remit Group

2.2 Figure 2.1 shows the composition of our remit group in each UK country and in the UK as a whole as at September 2010¹. Detailed categories of staff have been aggregated into broad staff groups, to enable cross-UK comparisons to be made²:

- Qualified nursing and midwifery staff was the largest group, at 33% of the total UK non-medical workforce, followed by administrative, estates and management (28%); and
- As health and social care are integrated in Northern Ireland, there are proportionally more professional, technical and social care staff in this country compared with others (30%, compared with a UK average of 18%).

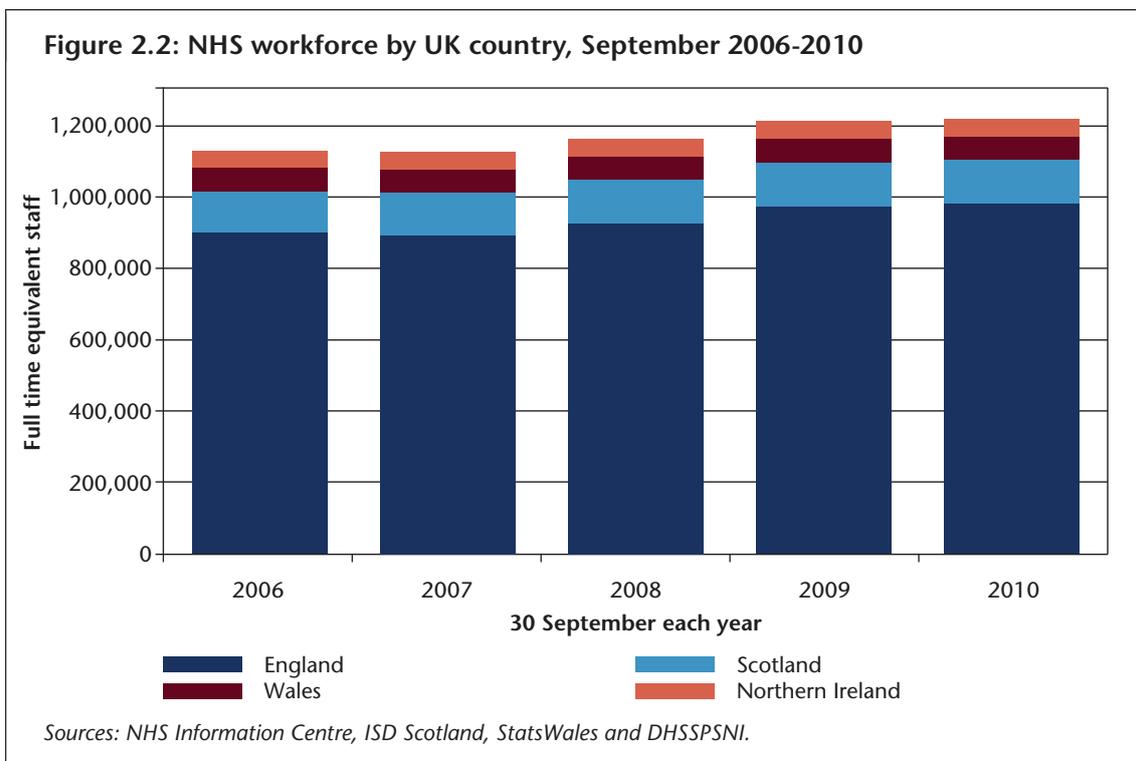


¹ The most recent date for which UK-wide data were available at the time of writing.

² Appendix C provides information on which categories of staff in each country have been allocated to broad staff groups. These comparisons should be treated with caution: some ancillary staff in England and Wales are categorised in the census as HCAs and support staff, but have job roles that fit better in the broad group 'administrative, estates and management'.

2.3 Figure 2.2 and Table 2.1 show changes in the non-medical NHS workforce between September 2009 and September 2010:

- The FTE non-medical NHS workforce increased by 0.5% (6,200 FTE) between September 2009 and September 2010, reaching a total of 1.22 million FTE (1.46 million headcount), a record high in the UK as a whole;
- The non-medical workforce in England increased by 0.8% between 2009 and 2010, compared with decreases of 0.8% in Scotland, 0.6% in Wales, and 1.1% in Northern Ireland;
- At UK level, the largest percentage increase was observed for professional, technical and social care staff, up 3.2% between 2009 and 2010. The largest decrease³ was observed for nursing and healthcare assistants and support staff, down 0.2%;
- Staff in England comprised 80% of the UK total; Scotland, 10%; Wales, 5%; and Northern Ireland, 4%⁴.



³ Except for 'other' staff, which represented just 3,700 (0.3%) of non-medical NHS staff in September 2010.

⁴ Individual items do not sum to 100% because of rounding.

Table 2.1: Change in NHS workforce by UK country and broad staff group, September 2009 - September 2010

Broad staff group	England	Scotland	Wales	Northern Ireland	UK
Qualified nursing & midwifery	-0.1%	-0.5%	0.2%	-0.6%	-0.1%
Nursing and healthcare assistants and support	0.0%	-2.1%	0.4%	-4.5%	-0.2%
Professional, technical & social care	3.6%	2.2%	2.5%	0.2%	3.2%
Ambulance	2.5%	-0.1%	1.8%	-1.2%	2.0%
Admin, estates & managers	0.6%	-1.4%	-4.0%	-1.7%	0.0%
Total (including 'Other' staff)	0.8%	-0.8%	-0.6%	-1.1%	0.5%

Sources: NHS Information Centre, ISD Scotland, StatsWales, and DHSSPSNI.

- 2.4 Between September 2010 and September 2011, the size of our remit group in Scotland decreased by 3.4% (4,145 FTE staff), with nearly all staff groups showing a decrease over this period. In Northern Ireland, the size of our remit group decreased by 0.6% (282 FTE staff).
- 2.5 Though not directly comparable with the annual workforce census, provisional, experimental data produced each month by the NHS Information Centre show that the FTE non-medical workforce in England decreased by 2.0% between September 2010 and October 2011, with over half of this accounted for by decreases in the number of FTE administrative, estates and management staff. Over the same period, the number of medical and dental staff increased by 1.8%.

Vacancies and Turnover

- 2.6 The vacancy survey in England was suspended in 2011. This collection is being reviewed as part of the national fundamental review of NHS data collections⁵, and the NHS Information Centre decided to suspend the survey for 2011 in order that resources could be devoted to other areas of workforce information⁶. We discuss our data requirements in Chapter 5.
- 2.7 Table 2.2 shows the latest vacancy rates by main staff group in other UK countries. Three-month vacancy rates in Scotland and Wales have shown little change over the year to 2011, but there have been increases in total vacancy rates in Scotland, and three-month and total vacancy rates in Northern Ireland.

⁵ Available at: <http://www.ic.nhs.uk/services/the-review-of-central-returns-rocr/fundamental-review-of-data-returns>.

⁶ A statement from the NHS Information Centre on this matter can be accessed at: <http://www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-and-gp-vacancies>.

Table 2.2: Vacancy rates by main staff group and UK country⁷

	Three-month vacancies		Total vacancies	
	Vacancy rate (%)	Percentage point change	Vacancy rate (%)	Percentage point change
Scotland (September 2011)				
Nurses, midwives & HVs bands 5-9	0.2	-0.1	1.0	+0.2
Nurses, midwives & HVs bands 1-4	0.2	0.0	1.4	+0.5
Allied health professionals	0.5	+0.1	2.1	+0.8
Wales (March 2011)				
Qualified nurses, midwives & HVs	0.0	-0.3	Data not collected	
Unqualified nurses, HCA & support	0.0	0.0		
Professional & technical	0.1	0.0		
Administrative and estates staff	0.1	-0.1		
Northern Ireland (March 2011)				
Nursing, midwifery & health visiting	0.6	+0.1	2.0	+1.0
Professional & technical	1.2	+0.6	3.0	+1.5
Social services	0.5	+0.1	1.7	+0.4
Administrative and clerical	0.6	+0.3	2.4	+1.5

Sources: NHS Information Centre, ISD Scotland, StatsWales, and DHSSPSNI.

- 2.8 Table 2.3 shows the latest available joining and leaving rates in England, Scotland and Northern Ireland. Leaving rates are higher than joining rates, reflecting the recent decline in workforce numbers.

⁷ For Wales and Northern Ireland, the table shows data for March 2011, and change on March 2010 values. For Scotland, the table shows data for September 2011, and change on September 2010 values.

Table 2.3: Leaving and joining rates to the NHS (all figures based on headcount staff)

	Leaving rate (%)	Joining rate (%)
England (year to 31 October 2011)		
All NHS (exc bank, trainee doctors & locums)	8.5	6.4
Qualified nursing, midwifery & health visiting	7.8	6.8
Scotland (year to 31 March 2011)		
All NHS (inc medical and dental)	7.1	4.3
Nursing & midwifery	5.8	3.0
Allied health professions	6.0	4.1
Other therapeutic services	8.6	8.3
Administrative services	7.4	3.8
Northern Ireland (year to 31 March 2011)		
All non-medical staff	5.3	3.4
Nursing & midwifery	4.3	2.3
Professional & technical	4.7	4.1
Social services	6.1	3.0
Administration & clerical	5.7	4.3

Sources: NHS Information Centre, ISD Scotland, StatsWales, and DHSSPSNI.

Earnings of Our Remit Group

Median Earnings in England

2.9 Figure 2.3 shows the median basic salary⁸ and total earnings⁹ per 'worked full time equivalent'¹⁰ by staff group in the second quarter of 2011:

- Managers had the highest basic salary and total earnings per worked FTE, at £45,300 and £46,600 respectively. The median total earnings of the next highest earning group, qualified scientific, therapeutic and technical staff (ST&Ts) were £10,500 lower, at £36,100. Qualified ambulance staff, qualified allied health professionals (AHPs) and qualified nurses also had median total earnings in excess of £30,000;
- The median basic salary for qualified ambulance staff was substantially lower than total earnings, probably because of significant overtime payments¹¹. Qualified nurses and maintenance and works staff also had a large difference between median basic salary and total earnings.

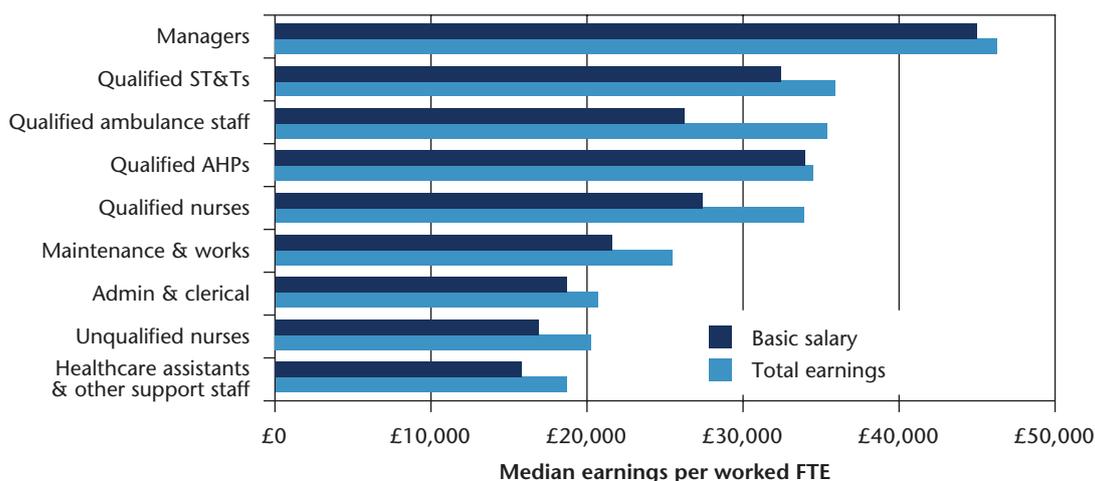
⁸ Basic salary is an individual's AfC spine point.

⁹ Total earnings include: hours-related pay, such as on-call, shift working and overtime; location payments such as location allowances and other local payments; recruitment and retention premia; and 'other' payments such as occupational absence and protected pay.

¹⁰ Earnings per worked FTE is a notional figure showing how much would be paid, on average, if all staff worked full time. It is calculated by taking the sum of earnings for a staff group, and dividing by the number of paid hours worked. Unpaid hours are not recorded on ESR.

¹¹ Successive NHS Staff Surveys have shown that most ambulance staff regularly work overtime, and are the staff group most likely to be paid for doing so.

Figure 2.3: Basic salary and total earnings by main staff groups, England, April-June 2011



Source: NHS Information Centre.

2.10 Table 2.4 shows recent changes in median total earnings and basic salary per worked FTE. Comparing April-June 2011 with the same period in 2010:

- Managers had the largest increase in median basic salary (8.4%)¹², with qualified ambulance staff the only group showing a decrease (-0.4%).
- Managers had the largest increase in median total earnings between 2010 Q2 and 2011 Q2 (4.3%), followed by unqualified nurses and administrative and clerical staff (both 3.0%). Median total earnings decreased for qualified AHPs and qualified ambulance staff.

Table 2.4: Changes in median basic salary and total earnings in England by main staff group, 2009-2011

	Change in median basic salary (%)		Change in median total earnings (%)	
	2009 Q2 – 2010 Q2	2010 Q2 – 2011 Q2	2009 Q2 – 2010 Q2	2010 Q2 – 2011 Q2
Qualified nurses	2.6	0.4	2.4	1.2
Unqualified nurses	3.1	1.2	2.6	3.0
HCA's & other support staff	3.4	4.6	3.4	2.2
Qualified AHPs	2.4	0.0	1.2	-0.3
Qualified ST&Ts	5.5	0.3	2.3	0.0
Qualified ambulance staff	n/a ¹³	-0.4	n/a ¹³	-0.8
Managers	n/a ¹⁴	8.4	n/a ¹⁴	4.3
Admin & clerical	2.2	1.1	3.6	3.0
Maintenance & works	2.5	3.8	0.0	0.8

Source: NHS Information Centre.

¹²Part of the large apparent increase in managers' earnings can be attributed to a compositional change in this group: compared with the previous year, there were 12% fewer managers in the sample in the earnings report (reflecting Government policy to reduce the amount the NHS spends on management), but the reduction in staff was disproportionately more in lower bands than in higher bands (for example, around -40% in Bands 4 and 5 compared with -3% in Bands 8b-9).

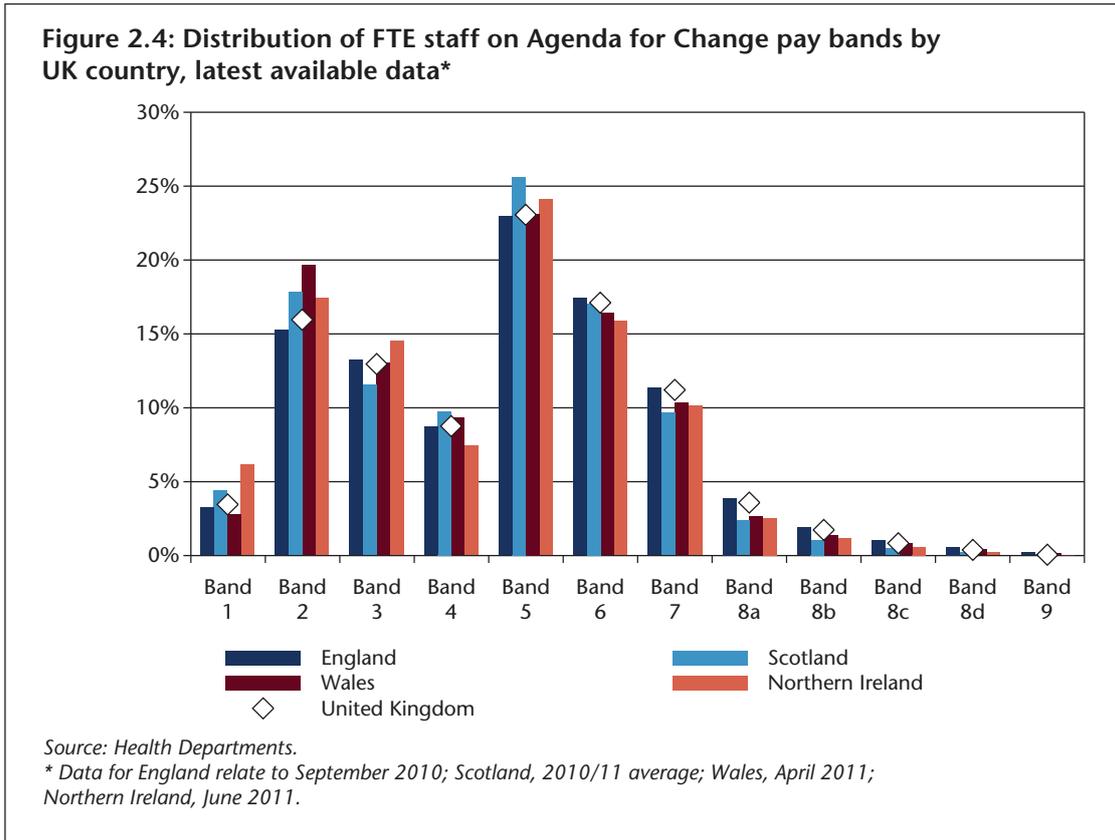
¹³Prior to 2010 Q2, data for ambulance staff were divided into 'London' and 'outside London'. From 2010 Q2 onwards, data have been combined, causing a discontinuity.

¹⁴Prior to 2010 Q2, data for ambulance staff were divided into 'London' and 'outside London'. From 2010 Q2 onwards, data have been combined, causing a discontinuity.

Distribution of Staff on Agenda for Change Bands

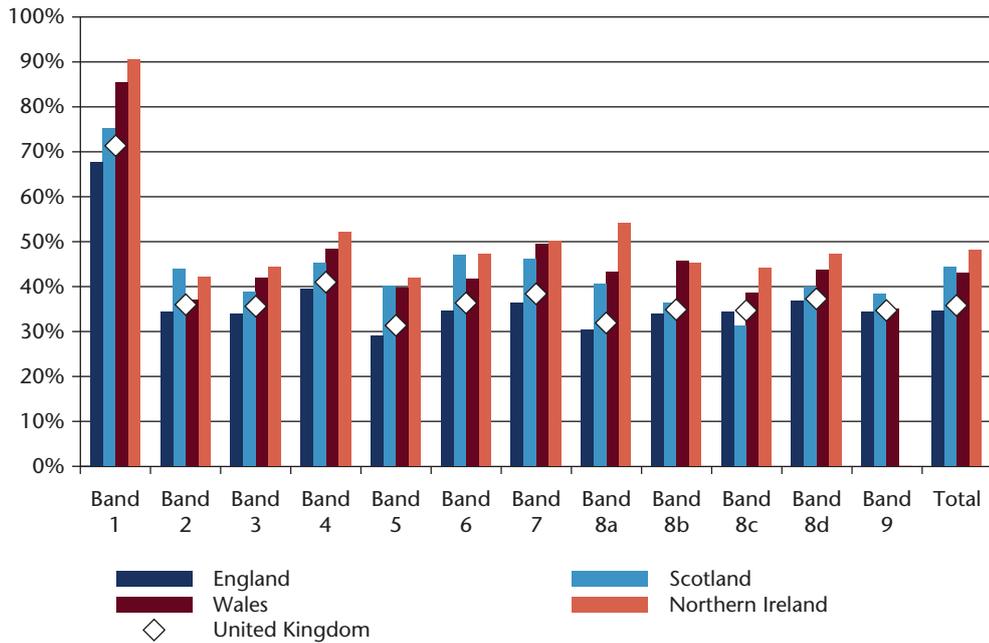
2.11 The distribution of our remit group across the Agenda for Change pay structure is shown in Figure 2.4. The pattern is similar for each UK country, with peaks at Bands 2 and 5, reflecting the main entry bands for clinical support workers and professionally-qualified clinical staff respectively.

2.12 Figure 2.5 shows the percentage of staff at the top of each AfC pay band, for each UK country. Typically 30% to 40% of staff were at the top of each band (with Band 1 a notable outlier¹⁵); overall, 37% of staff in the UK were at the top of their pay bands, compared with 32% a year ago. England tended to have a lower percentage of staff at the top of pay bands than was the case in other countries.



¹⁵ Band 1 of AfC contains only three spine points, the fewest of all bands. Scotland was still using spine point 1 at the time these data were collected.

Figure 2.5: Percentage of staff at the top of pay bands by UK country, latest available data*



Source: Health Departments.

* Data for England relate to September 2010; Scotland, 2010/11 average; Wales, April 2011; Northern Ireland, June 2011.

Relative Earnings of Our Remit Group

2.13 We have used data from the *Annual Survey of Hours and Earnings (ASHE)* to track changes in median gross weekly pay¹⁶ for our remit group, compared with other employees, as shown in Table 2.5, though this does not take into account differences in workforce characteristics:

- Median pay for the remit group as a whole exceeds that in the wider economy and in the private sector, but is less than in the public sector. The increase in median pay for NHS PRB staff between 2009 and 2010 exceeded that in the whole economy and the public sector;
- NHS nurses' and midwives' median pay was more than that for 'associate professional and technical occupations'¹⁷.

¹⁶Gross weekly (as at April 2011), rather than annual (the year to March 2011) pay is used, as it represents a more up-to-date indicator.

¹⁷Under the Standard Occupational Classification (SOC) codes, nurses and midwives are contained within major group 3: 'associate professional and technical occupations'.

Table 2.5: Median gross weekly pay for full time employees at adult rates, April 2009-2011

NHSPRB remit group:	Median gross weekly pay (£)			Change (%)	
	April 2009	April 2010	April 2011	2009-10	2010-11
All NHSPRB employees	514	524	529	1.9	1.0
NHS nurses & midwives	590	599	606	1.6	1.1

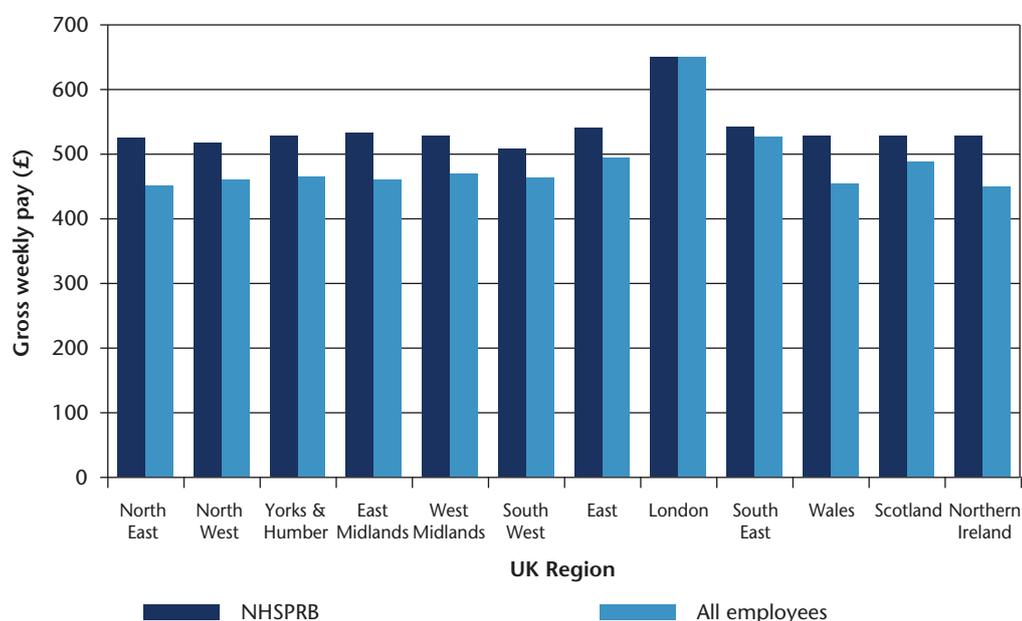
Wider economy¹⁸:

All employees	489	499	501	2.0	0.4
Public sector	538	554	556	3.0	0.3
Private sector	464	473	476	1.9	0.8
Professional occupations ¹⁹	697	705	712	1.2	1.0
Associate professional and technical occupations ²⁰	551	563	561	2.1	-0.4
Administrative & secretarial occupations	374	381	383	2.1	0.5

Source: ONS (Annual Survey of Hours and Earnings).

2.14 Median earnings for the NHSPRB remit group by UK region are shown in Figure 2.6, alongside those for all employees. Earnings of the NHSPRB remit group are highest in London, but are fairly similar in the rest of the UK. The difference in median pay for the remit group and all employees is smallest in London (0%) and highest in Northern Ireland (17.5%).

Figure 2.6: Median gross weekly pay for full time employees by region, April 2011



Source: OME analysis of ASHE microdata (NHSPRB); Office for National Statistics (all employees).

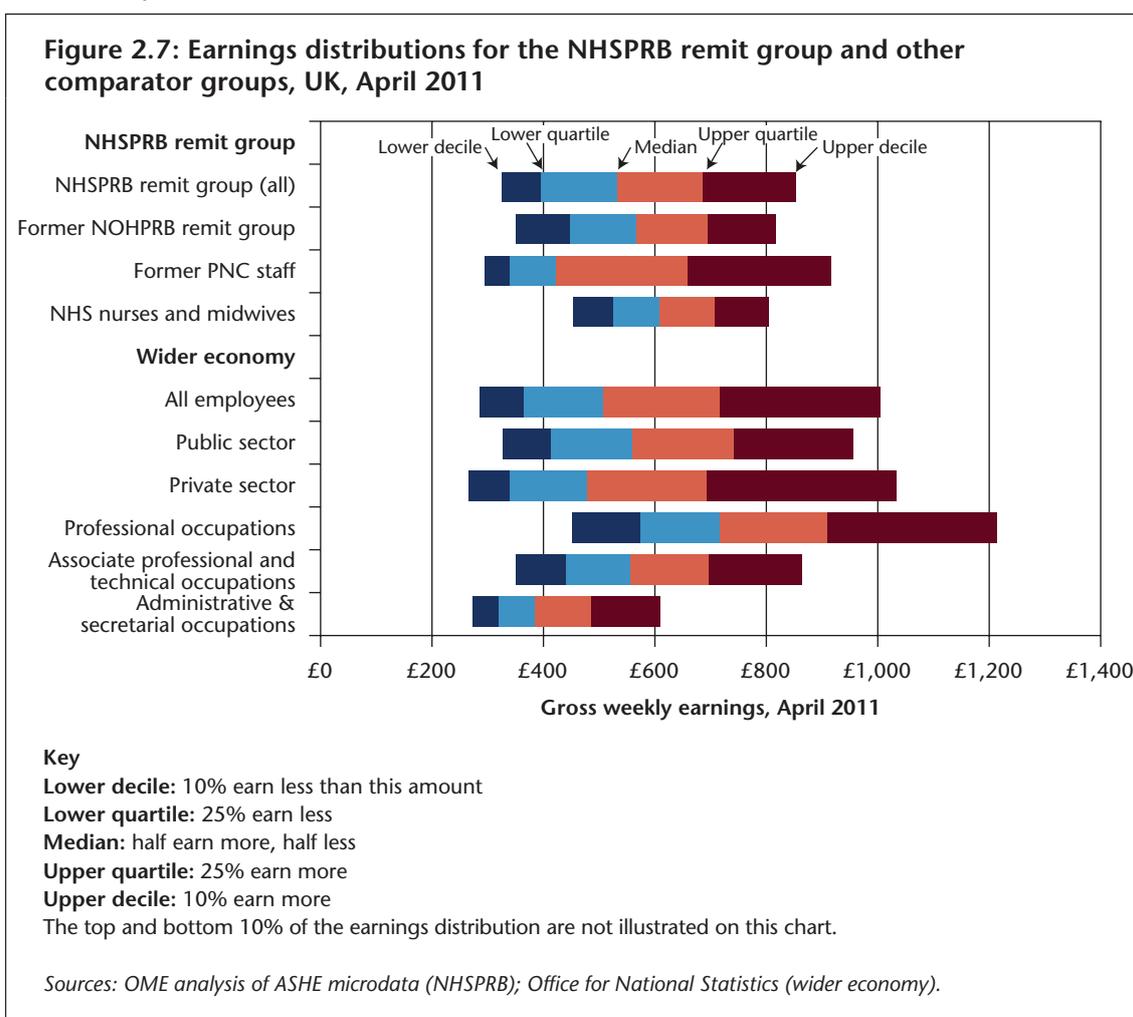
¹⁸ With the exception of 'private sector', all categories include NHSPRB staff.

¹⁹ For example teachers, solicitors, accountants, doctors and some AHPs and ST&Ts.

²⁰ For example nurses, police officers and some AHPs and ST&Ts.

2.15 Figure 2.7 shows the distribution of earnings of our remit group in April 2011, alongside equivalent information for other employees:

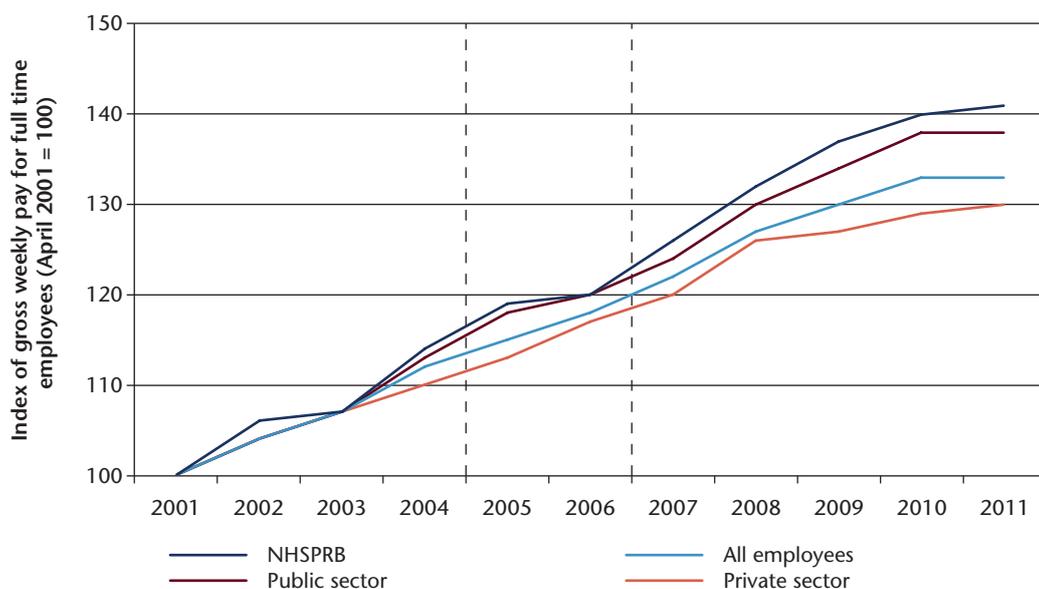
- The earnings distribution for the NHSPRB remit group is more compressed than that for all employees. The middle 50% of staff are contained in a much narrower range of earnings;
- The lower decile and quartile earnings for the remit group are higher than for all employees (implying a smaller proportion of “low” earners). Conversely, the upper quartile and decile are at a lower level (implying few “high” earners);
- The distribution of NHSPRB earnings is slightly narrower than that for the wider public sector.



2.16 Figure 2.8 and Table 2.6 show growth in median gross weekly pay for our remit group and other employees since 2001. Care must be taken in interpreting these figures as the skill profile and composition of the workforce may have changed over time:

- Median pay for our remit group increased by 41% over a 10-year period, compared with 33% for all employees. Median pay for our remit group also increased relative to the public and private sectors (Figure 2.8);
- Earnings for the remit group increased at approximately the same rate across the earnings distribution – around 41% to 44% between 2001 and 2011 – with the exception of the upper decile, which increased by nearly 54% over the 10-year period (Table 2.6). A similar pattern was seen in other sectors.

Figure 2.8: Growth in median gross weekly pay for the NHSPRB and other employee groups, April 2001-2011



Source: OME analysis of ASHE.

Dashed vertical lines indicate discontinuities in the 2004 and 2006 ASHE surveys.

Table 2.6: Growth in gross weekly pay percentiles for full time employees between 2001 and 2011

	Growth between April 2001 and April 2011 (%)				
	10th percentile	25th percentile	Median	75th percentile	90th percentile
NHSPRB	44	42	41	43	54
All employees	35	33	33	35	37
Public sector	42	42	38	41	44
Private sector	32	29	30	31	35

Source: OME analysis of ASHE.

2.17 For many occupations in our remit group, such as registered clinical staff, the NHS is the major employer; for others, such as administrative and clerical staff, the NHS competes in a wider labour market. Direct comparisons between the average pay of our remit group and other sectors are difficult to make, as the characteristics of our remit group may differ significantly from any comparator group.

2.18 There have been several attempts to quantify the difference in pay between the public and private sectors, using econometric techniques in order to account for differences in the characteristics of the respective workforces. Recent examples of such analysis have been published by the Institute for Fiscal Studies (IFS)²¹ and the Office for National Statistics (ONS)²²:

²¹ IFS (February 2011), *Green Budget Chapter 7: Public Sector Pay and Pensions*. Available at: <http://www.ifs.org.uk/publications/5460>.

²² Damant.A and Jenkins.J (July 2011), *Estimating Differences in Public and Private Sector Pay*, Office for National Statistics.

- The IFS estimated that, for the period January 2009 to September 2010, public sector workers were paid on average 7.5% more than private sector workers, taking into account their gender, age, level of education and qualifications held. The IFS found that the differential had increased since 2008, but was not significant in London or the South East;
- The ONS estimated that the differential in average hourly pay (excluding overtime) in favour of the public sector was 7.8% in April 2010, compared with 5.3% in April 2007.

2.19 The IFS also estimated the effect on the average pay differential between the public and private sectors implied by the current policy of a two-year pay freeze: its calculations suggested that the differential would reduce to 0.9% in favour of the public sector by the end of the current pay freeze in 2013.

2.20 Though these analyses are useful to some extent, there are limitations regarding their applicability to our remit group: the differential for the NHS alone may be different to that of the wider public sector. Additionally, there may be occupations or groups of occupations where the differential against the private sector, taking into account their particular characteristics, may be substantially different from an overall average differential²³. This may not be possible to address within a pay system specifically designed to deliver equal pay for work of equal value in the NHS.

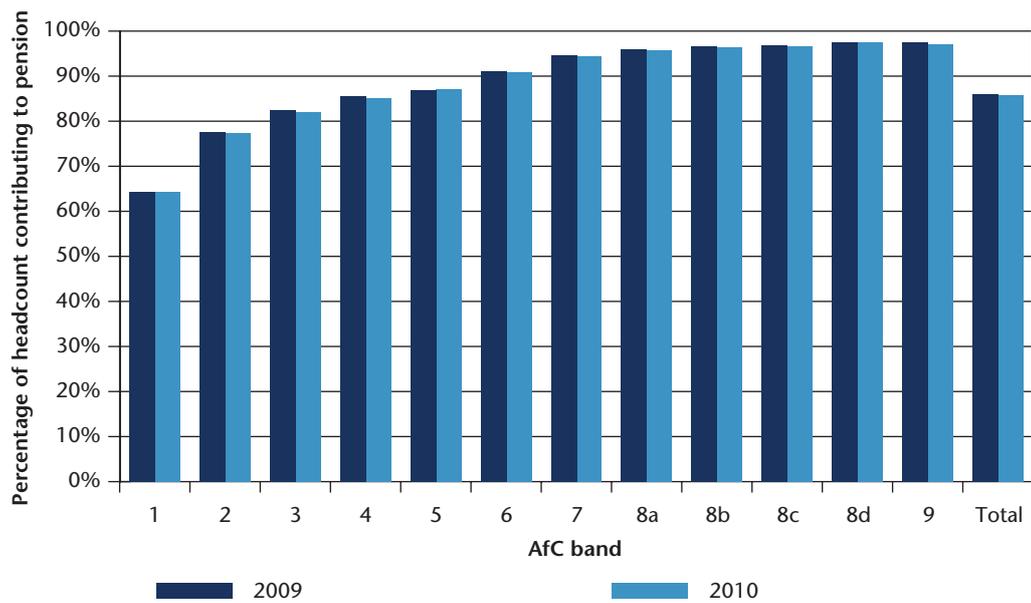
Membership of the NHS Pension Scheme

2.21 The Department of Health provided estimates of the percentage of non-medical staff (on a headcount basis) in England who are members of the NHS Pension Scheme. Figure 2.9 shows that, overall, 86% of staff contributed to the NHS Pension Scheme in both 2009 and 2010, and that the percentage of staff contributing to the scheme tended to increase with AfC bands.

2.22 The Department's figures also demonstrated that there is an association between age and scheme membership: staff aged under 30 or over 59 were least likely to contribute to the scheme. Figure 2.10 shows that the effects of lower membership rates for the lowest AfC bands, and the youngest and oldest age groups, are additive: less than half of staff aged under 25 and in AfC Band 1 were members of the scheme in September 2010.

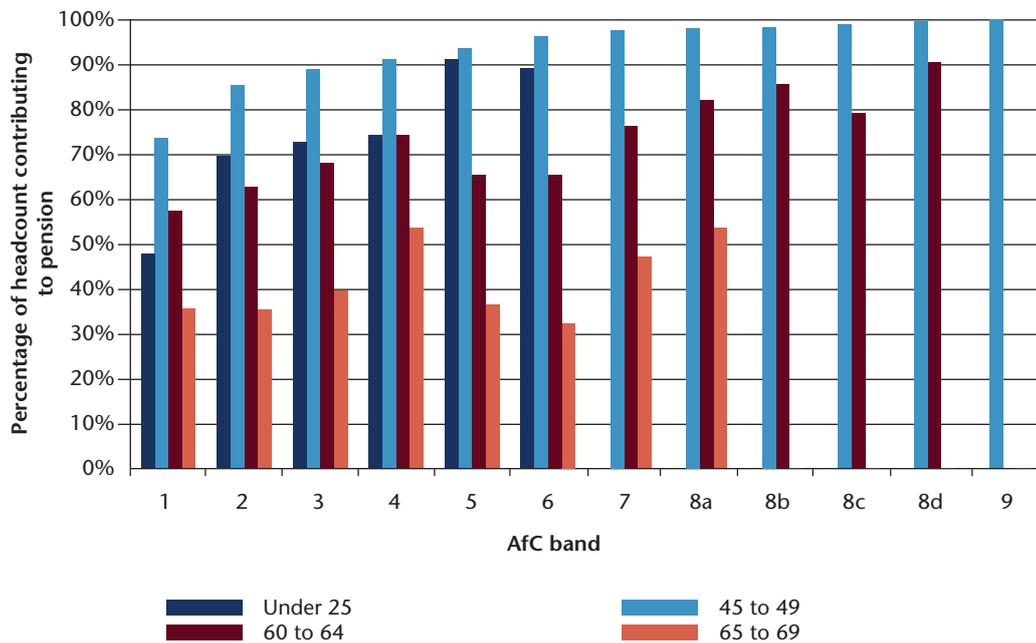
²³For example, a highly-specialist scientist in our remit group could have a negative differential, compared to private sector workers with comparable qualifications.

Figure 2.9: Estimated pension membership rate by Agenda for Change band, England, September 2009-2010



Source: Department of Health.

Figure 2.10: Estimated pension membership rate by Agenda for Change band and age, England, September 2010



Source: Department of Health.

Chapter 3 – Agenda for Change Staff Earning £21,000 or Less

Introduction

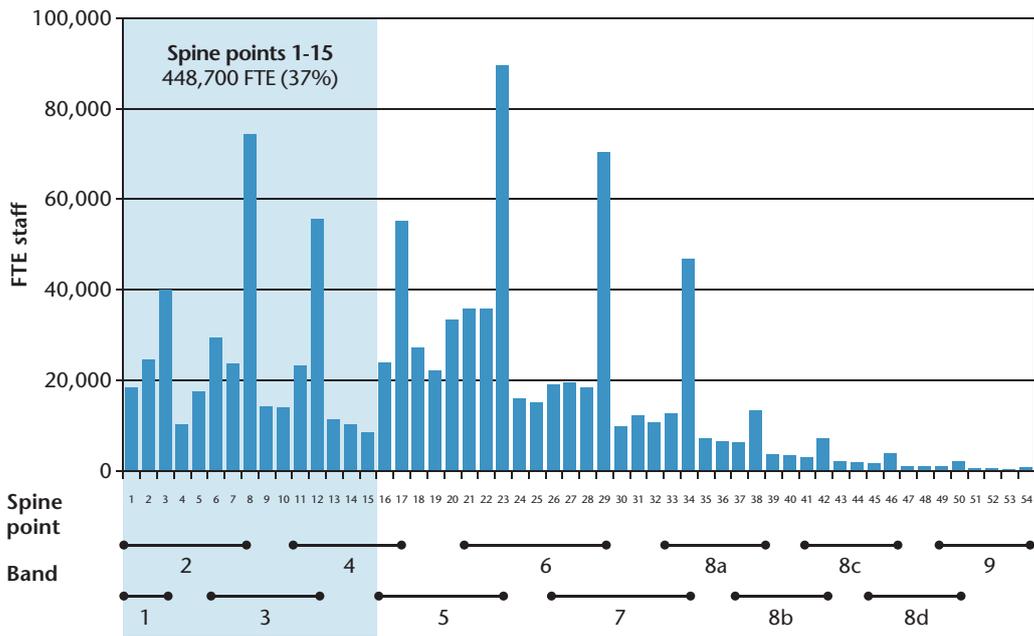
- 3.1 In this chapter we examine the specific evidence presented under our remit for 2012/13 to consider pay increases for Agenda for Change (AfC) staff earning £21,000 or less. We set out below the composition of the AfC staff group earning £21,000 or less followed by the relevant evidence and information from other sources for this group relating to the economy, inflation, labour market and earnings, the funds available to the Health Departments, and recruitment and retention. We then conclude this chapter with our comments and recommendation.

AfC Staff Earning £21,000 or Less

- 3.2 The Chief Secretary to the Treasury's letter of 20 June 2011 and those from the Secretary of State and Devolved Administrations sought our recommendations on uplifts for workers earning £21,000 or less. These included definitions of pay (set out in full in paragraph 3.65) which, for NHS staff employed under AfC terms and conditions, apply to those paid at or below AfC spine point 15 in Band 4 which is currently £20,804. The first AfC spine point above the limit is spine point 16 which is currently £21,176 – the bottom point of Band 5 and equivalent to the starting salary for qualified nurses and many other professionally qualified clinical staff.
- 3.3 The estimated distribution of our remit group by AfC spine point is shown in Figure 3.1, with the shaded area indicating the number of staff in our remit group paid at or below spine point 15. According to the latest available data in each UK country, approximately 448,700 FTE staff (37% of the remit group) were paid at or below spine point 15, a decrease of around 9,400 FTE staff (1.5 percentage points) compared to the 2010 estimate¹. In England, 36% of staff were paid under the threshold; in Scotland, 39%; in Wales, 40%; and in Northern Ireland, 41%, with the percentage having decreased slightly in each country. Of those staff paid £21,000 or less, approximately 34% are at the top of their pay bands, compared with 37% in the remit group as a whole (see Figure 2.5).

¹ An error in our estimate in our Twenty-Fifth Report of the number of staff paid at or below spine point 15 has been identified: in Northern Ireland, headcount data rather than full time equivalent data were used, which had the effect of inflating the *number* of FTE staff in the UK paid at or below spine point 15 by approximately 8,170, and the *percentage* of staff by approximately 0.3 percentage points. Revised estimates for 2009/10 are 458,100 FTE staff, 38.5% of the remit group. Corrected data have been used when making year-on-year comparisons above.

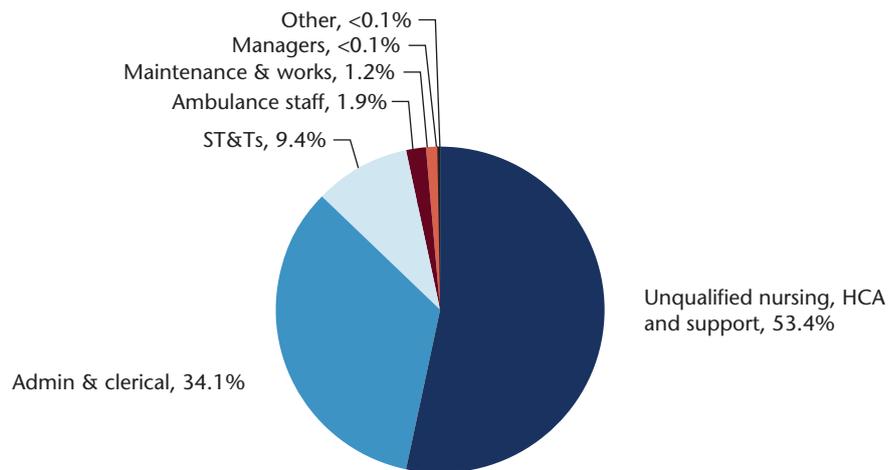
Figure 3.1: Distribution of Agenda for Change staff by spine point, United Kingdom, latest data*



Source: Health Departments.
 *Data for England relate to September 2010; Scotland, 2010/11 average; Wales, April 2011; Northern Ireland, June 2011.

- 3.4 Figures 3.2 to 3.5 show the composition of FTE staff paid £21,000 or less in each UK country. The majority of staff can be broadly categorised as unregistered nursing and healthcare assistants, administrative staff and support services. The Department of Health’s evidence provides a number of specific job roles within these categories, for example healthcare assistant, clerical worker, housekeeper, porter, laboratory assistant, receptionist and secretary. We make the assumption that this is mirrored in other UK countries.
- 3.5 In Northern Ireland, as health and social care are integrated, in addition to the groups named above some social services staff – home helps and social care support staff (but not qualified social workers) – were also paid at or below spine point 15.

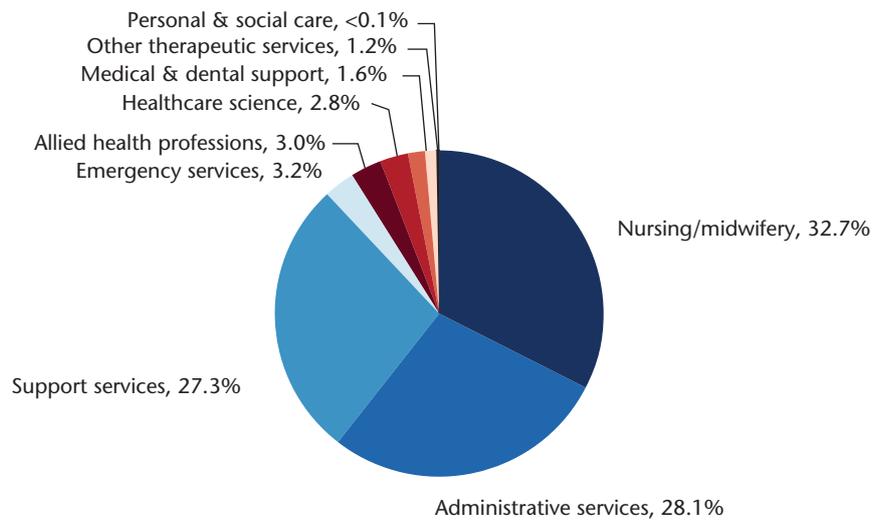
Figure 3.2: Composition of FTE staff paid at or below AfC spine point 15 in England, September 2010



Source: Department of Health.

Total: 356,400 FTE staff

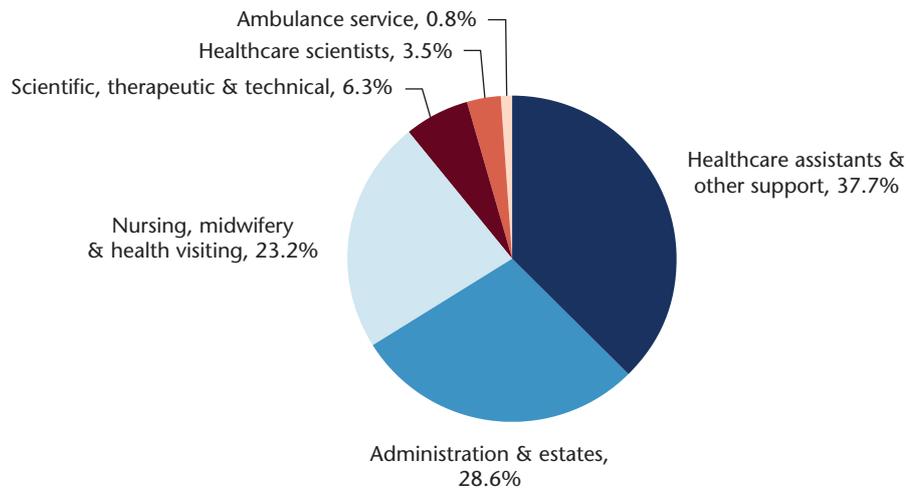
Figure 3.3: Composition of FTE staff paid at or below AfC spine point 15 in Scotland, average 2010/11



Source: Scottish Government Health and Social Care Directorates.

Total: 46,100 FTE staff

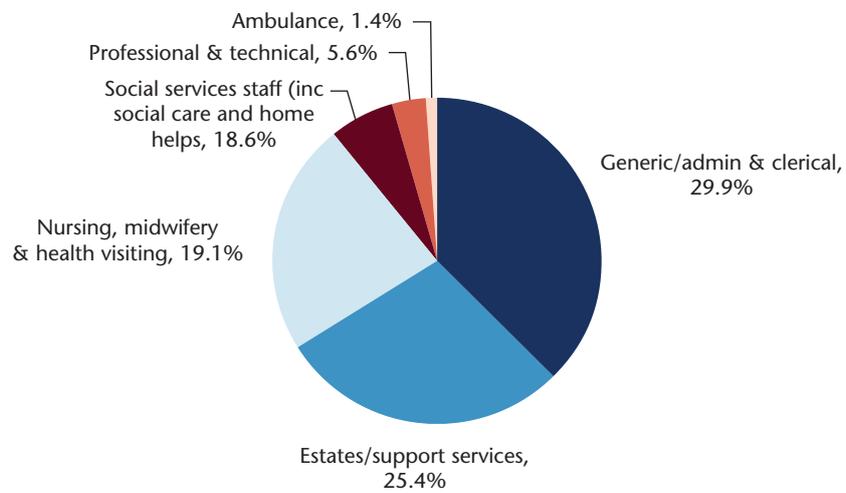
Figure 3.4: Composition of FTE staff paid at or below AfC spine point 15 in Wales, April 2011



Source: Welsh Government.

Total: 26,000 FTE staff

Figure 3.5: Composition of FTE staff paid at or below AfC spine point 15 in Northern Ireland, June 2011



Source: Department of Health, Social Services and Public Safety.

Total: 20,100 FTE staff

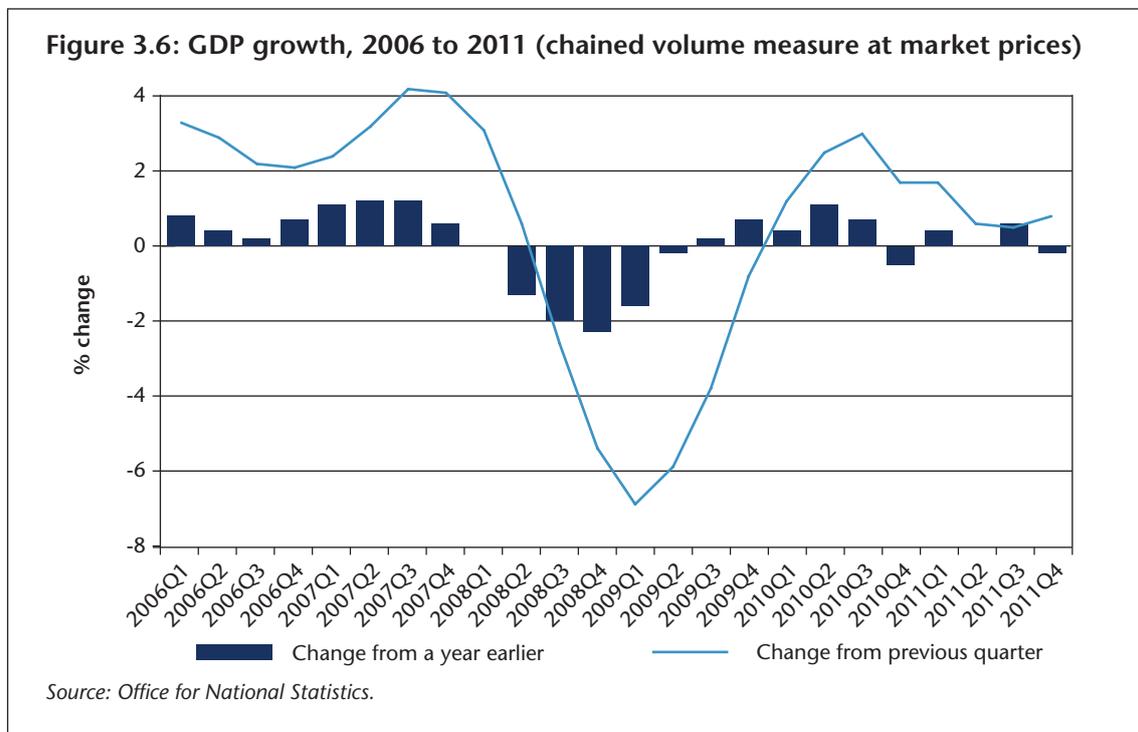
Economy, Inflation, Labour Market and Earnings

3.6 Our assessment below is based on the latest economic indicators available at the time of submission of this report.

Economic Growth

3.7 GDP grew by 0.9% during 2011 (see Figure 3.6). This was substantially below the forecast made at the start of 2011. Recent economic forecasts saw a downgrading of growth expectations. The most recent set of forecasts from the Treasury panel of independent experts in January 2012² estimated GDP growth of 0.4% for 2012, compared to a forecast of 2.1% in March 2011.

3.8 This followed a substantial downgrading of growth expectations from the Office for Budgetary Responsibility (OBR)³ in November 2011. It revised down its forecasts for GDP growth in 2012 to 0.7% from the 2.5% forecast in March 2011. It expected GDP to be broadly flat in the first half of 2012, but to gain momentum gradually though the year assuming that the euro area found its way through the current crisis.



3.9 The Bank of England also reduced its growth forecasts for 2012 significantly in its November 2011 inflation report, from 2.1% to 1.3%. In doing so, the Bank of England said that “the marked deterioration in the external environment, together with the domestic headwinds stemming from the fiscal consolidation and squeeze on households’ real incomes, means that growth looks set to be weak in the near term. The recovery is likely to gather pace over the second and third years of the forecast as private demand picks up, supported by continuing stimulus from monetary policy and a gentle recovery in real incomes”⁴.

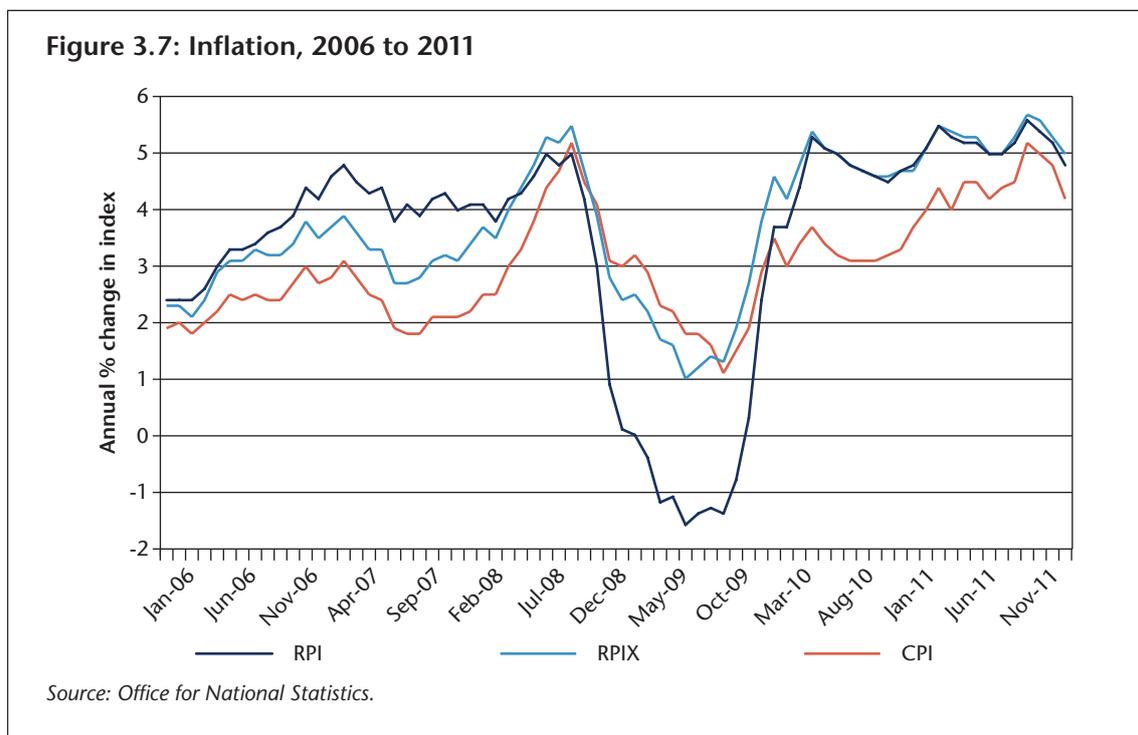
² HM Treasury, *Forecasts for the UK Economy: A Comparison of Independent Forecasts*, January 2012. Available at: <http://www.hm-treasury.gov.uk/d/201201forecomp.pdf>.

³ Office for Budgetary Responsibility, *Economic and Fiscal Outlook*, November 2011. Available at: http://cdn.budgetresponsibility.independent.gov.uk/Autumn2011EFO_web_version138469072346.pdf.

⁴ Bank of England, *Inflation Report*, November 2011.

Inflation

3.10 In the context of the four Governments' public sector pay policies, we note that inflation rates have been significantly higher and forecasts have been revised upwards, and continue to carry risks of revision, since the UK Government announced its public sector pay policy in June 2010. At the time the policies were announced, OBR forecasts⁵ for 2011 Q4 were for CPI inflation to be 2.4% and RPI inflation to be 3.2%. Whereas by December 2011, CPI inflation was 4.2% and RPI inflation was 4.8% (see Figure 3.7). All inflation measures had been held relatively high though 2011 by significant price rises for tobacco, fuel, car insurance, and transport services. The Governor of the Bank of England had written to the Chancellor in each of the last eight quarters to explain why inflation was above its target. Most recently in November 2011⁶ he said that the current high level of inflation reflected the increase in the standard rate of VAT earlier in 2011 and previous steep increases in import and energy prices, including recent domestic utility price rises. He concluded that in the absence of those temporary factors, it was likely that inflation would be below the 2% target.



3.11 Inflation forecasts suggest that CPI inflation would fall back sharply at the start of 2012, when the VAT rise would drop out. Forecasts indicated that CPI inflation would head towards 2% by the end of 2012. RPI inflation was forecast to drop down to just below 3% by the end of 2012⁷.

Labour Market

3.12 The labour market deteriorated significantly in the second half of 2011. The employment level fell by 160,000 in the six months to November 2011, having shown growth over the previous two years (see Figure 3.8), driven by population growth and increasing labour market participation.

⁵ Office for Budgetary Responsibility, *Budget Forecast*, June 2010. Available at: http://budgetresponsibility.independent.gov.uk/wordpress/docs/junebudget_annexc.pdf.

⁶ Available at: <http://www.bankofengland.co.uk/monetarypolicy/pdf/cpiletter111115.pdf>.

⁷ HM Treasury, *Forecasts for the UK Economy: A Comparison of Independent Forecasts*, January 2012. Available at: <http://www.hm-treasury.gov.uk/d/201201forecomp.pdf>.

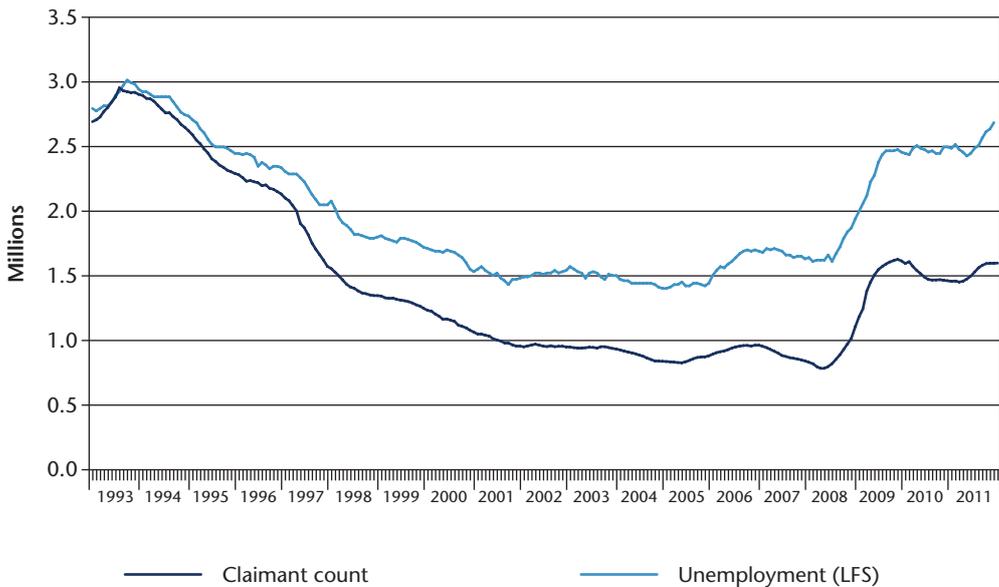
Figure 3.8: Total employment, rate and level, 2001 to 2011



Source: Office for National Statistics.

- 3.13 Figures from the Labour Force Survey suggested that private sector employment grew by 262,000 in the year to September 2011, while public sector employment fell by 276,000.
- 3.14 The level of unemployment, measured by the Labour Force Survey, was broadly stable over the two years from mid-2009 to mid-2011, kept steady by the opposing trends of rising employment and rising economic activity (see Figure 3.9). Since then, unemployment had risen significantly, by 233,000 in the six months to November 2011, to 2.69 million (8.3%), the highest level since August 1994.

Figure 3.9: LFS unemployment and claimant count, 1992 to 2011



Source: Office for National Statistics.

3.15 The OBR forecast in November 2011 that employment levels will be broadly unchanged between 2011 and 2012 but will gradually pick up from 2012. In line with a weaker outlook for GDP growth, the OBR revised up its projected level of unemployment from 2.5 million to 2.8 million in 2012. The unemployment rate was expected to rise, rather than fall, in 2012. Between the start of 2011 and the start of 2017, the OBR expected total employment to increase by around 1 million. Within this, private sector employment was expected to increase by around 1.7 million, offsetting a total reduction in general government employment of around 710,000.

Average Earnings Growth and Pay Settlements

3.16 Private sector average earnings growth remained modest throughout 2011, at 2.0% in the three months to November 2011. Public sector average earnings growth (excluding the nationalised banks) was at 1.4% in the three months to November 2011 (see Figure 3.10).



3.17 The OBR revised down its forecast for earnings growth in November 2011, in line with higher expected unemployment and lower productivity growth⁸. It expected wage growth of around 2% in 2012, picking up gradually to 4.5% from the second half of 2014. Adjusted for inflation, this implied negative real wage growth until the start of 2013. The Treasury's average of independent forecasts expected slightly higher average earnings growth of 2.4% in 2012⁹.

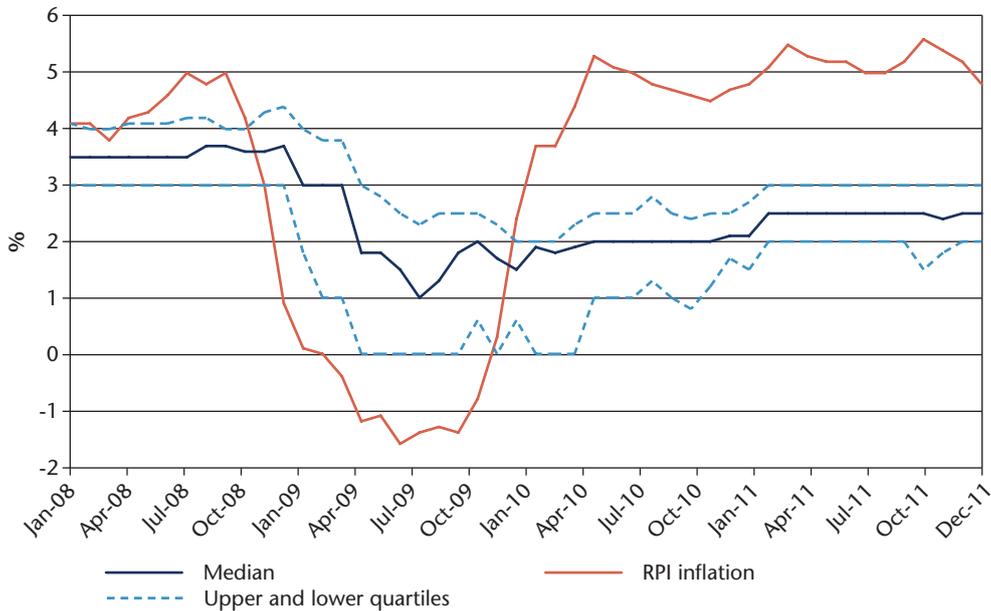
3.18 The median pay settlement level was stable at around 2.5% throughout 2011, up slightly from 2.0% in 2010, on the Incomes Data Services (IDS) measure (see Figure 3.11). Pay settlement levels were below inflation throughout 2010 and 2011. According to settlements monitored by IDS, only 8% of private sector pay settlements in 2011 had

⁸ Office for Budgetary Responsibility, *Economic and Fiscal Outlook*, November 2011. Available at: http://cdn.budgetresponsibility.independent.gov.uk/Autumn2011EFO_web_version138469072346.pdf.

⁹ HM Treasury, *Forecasts for the UK Economy: A Comparison of Independent Forecasts*, January 2012. Available at: <http://www.hm-treasury.gov.uk/d/201201forecomp.pdf>.

been freezes compared to 20% in 2010. The vast majority of public sector pay reviews had been freezes, with the exception of a 1.4% pay increase at Royal Mail and the Post Office.

Figure 3.11: Pay settlements, 2008 to 2011 (three-month average)



Sources: Incomes Data Services, Office for National Statistics.

Evidence from the Parties

3.19 The parties’ evidence was submitted in September and October 2011 and therefore reflects the economic and labour market indicators available up to the time of submission.

The Health Departments

3.20 The **Department of Health** provided the overview of the general economic context for the UK. The Government considered that the UK economy was still recovering from the deepest recession in living memory during which GDP fell by 6.4%. In March 2011, the OBR forecast GDP to grow 1.7% over 2011 rising to above-trend rates from 2012. The Government added that output expanded for the first half of 2011 but it was less than forecast by the OBR.

3.21 The Government commented that global conditions were making the recovery more difficult and, while it had taken action to tackle the deficit, the UK was not immune to risks posed by deteriorating global confidence and instability in financial markets. The Government considered Britain’s deficit was the largest in its peacetime history and it was committed to a fiscal mandate which would achieve cyclically-adjusted current balance by the end of the rolling, five-year forecast horizon. At Budget 2011, the Government reaffirmed its aim to restore the structural current deficit to balance over the course of the Parliament. Net borrowing in the year (to the time of the evidence) was broadly in line with the OBR’s forecast but there remained substantial uncertainty over the medium term particularly in relation to market sentiment towards high-deficit countries. The Government concluded, therefore, that the UK faced significant risks until fiscal sustainability was restored.

- 3.22 The Government noted that inflation had been elevated due to the rise in global commodity prices combined with the temporary rise in VAT and, as these fell out of the comparison and economic spare capacity exerted downward pressure, inflation was expected to fall back in 2012 and 2013.
- 3.23 Overall, the Government considered the labour market had a long way to go before returning to pre-recession conditions and risks remained. It commented that employment had started to recover, driven by the private sector, but ILO unemployment was still close to its 8% peak in the second quarter of 2010. The Government felt that recruitment and retention potential remained strong in the economy as a whole including in the public sector. In this context, the Government continued to view the overall value of the public sector reward package as generous. It cited the ONS estimate that there was a public sector pay premium prior to the recession in 2007 at an average of 5.3% (controlling for the type and characteristic of employees) and that this premium widened to 7.8% in April 2010 as a result of a slowdown in annual nominal average earnings growth in the private sector.
- 3.24 The **Scottish Government Health and Social Care Directorates (SGHSCD)** stated that the slowdown in global recovery had also been felt by Scotland with GDP in the first quarter of 2011 growing by just 0.1% after a fall of 0.5% in the last quarter of 2010. Provisional data for the second quarter of 2011 indicated that the UK remained 4.1% below its pre-recession peak in output, while Scotland was 4.4% worse off. Independent forecasts for Scotland expected growth in GDP of around 1.25% in 2011 and further momentum expected to be gained in 2012 with growth in GDP between 1.5% and 2%.
- 3.25 The SGHSCD reported that the decline in Scottish output during the recession had led to deterioration in the Scottish labour market. The rate of employment had recovered slightly – increasing by 1.6% in the year to June 2010 – but the Scottish unemployment rate was 7.7% up from 3.1% prior to the recession. The Bank of Scotland Barometer for July 2011 indicated continued improvement in the labour market across a range of measures but the July 2011 PMI survey showed a marginal decline in the labour intensive service sector. The SGHSCD added that falling GDP growth and increasing unemployment had led to a significant reduction in nominal wage growth which still lagged behind inflation.
- 3.26 The SGHSCD concluded that the Scottish economy was forecast to experience a modest recovery in coming years but significant uncertainty surrounded these forecasts with recovery heavily dependent on conditions within the global economy, the stability of the Eurozone and the impact of the UK Government’s fiscal consolidation programme.
- 3.27 The **Department of Health, Social Services and Public Safety in Northern Ireland (DHSSPSNI)** told us that the global economic downturn continued to have a severe impact on the Northern Ireland labour market. Business sector activity¹⁰ had fallen in every month since December 2009 and Northern Ireland was the only region in the UK to have recorded a fall in business activity in the year to August 2011. Service sector output had decreased by 5.5% over the year to the first quarter of 2011 and construction sector output fell by 13.5% although manufacturing output increased by 6.4%. The DHSSPSNI concluded business conditions remained very challenging for most sectors.
- 3.28 The DHSSPSNI added that the local unemployment rate of 7.4% (July 2011) was the fourth lowest of the UK regions and the claimant count had increased consistently over the past year. The Northern Ireland economic inactivity rate of 27.2% remained the

¹⁰ *Ulster Bank Purchasing Managers’ Index*, August 2011.

highest of the UK regions. The DHSSPSNI cited Croner Reward¹¹ which indicated that consumer prices had increased by more in the UK (6.4% per annum) than in Northern Ireland (5.2% per annum).

NHS Employers (NHSE)

- 3.29 **NHSE** commented that the shortage of alternative jobs following the recession was likely to be the key reason NHS turnover had decreased. In the wider job market, Jobcentre Plus live unfilled vacancies had fallen from April 2010 to April 2011 for occupations equivalent to those in AfC Bands 1 to 4. NHSE added that NHS pay rates continued to be competitive with other sectors based on data from Incomes Data Services.

Staff Bodies

- 3.30 The **Staff Side** noted that the UK was emerging from the worst recession in 70 years although the prospects of recovery were far from certain. They pointed to high unemployment, few vacancies and economic activity sluggish at best. The Staff Side considered that the combination of high inflation, weak earnings growth and fiscal tightening had caused a fall in real disposable income. The OBR expected household incomes in 2011 to contract for a second year in a row with the Institute of Fiscal Studies stating that UK households were experiencing the most severe protracted fall in incomes since the 1970s.
- 3.31 The Staff Side noted that the UK Government's economic strategy centred on public spending cuts of £81 billion and tax rises of £29 billion by 2014/15 which was designed to boost investor confidence and improve private sector investment leading to growth in manufacturing and exports. The Staff Side raised concerns about further changes such as: freezing child benefit; cuts to child tax credits; caps on housing benefits; and CPI, rather than RPI, increases to benefits and pensions.
- 3.32 The Staff Side commented that both RPI and CPI inflation had been running ahead of NHS pay awards for the great majority of the last three years – RPI inflation above the award for 67% of the period since January 2008 and CPI inflation ahead for 79%. They added that the most striking aspect was the “ yawning gap ” opening up over the last year between inflation and NHS pay awards. The Staff Side also pointed to the HM Treasury's average of independent forecasts showing inflation remaining high for 2011 and falling by the end of 2012 but still meaning a “ giant gap ” between inflation and pay awards if a further pay freeze was imposed.
- 3.33 The Staff Side provided information on the effect of RPI inflation on wages between 2007 and 2012 for NHS staff at the top of their pay bands (Bands 1, 5 and 8a). From this information, they concluded that the best projections available suggested that inflation will have cut out between 6% and 10% from the value of staff wages by the end of the two-year pay freeze. In addition, the Staff Side highlighted that, according to Croner Reward¹², the lowest income group required the biggest rise in income to maintain their existing standard of living at 6.6% over the year. They cited the Institute of Fiscal Studies¹³ which found that the greater tendency of low income households to spend a higher proportion on fuel and water meant, on average, that they had higher inflation rates than higher income households. Finally, as part of their argument that inflation was running at a higher level for the lower paid, the Staff Side analysed changes in the price

¹¹ Croner Reward (September 2011) – *Cost of Living Comparisons*.

¹² Croner Reward (March 2011) – *Cost of Living Comparisons*.

¹³ Institute of Fiscal Studies (June 2011) – *The Spending Patterns and Inflation Experience of Low-Income Households* – Levell P and Oldfield Z.

of components of CPI and RPI over the year to June 2011. From which they highlighted increases to the most basic expenditure (e.g. housing, food and energy) which were most likely to impact on low paid staff.

- 3.34 The Staff Side commented on the growth in median pay settlements comparing the increase in private sector settlements from 0.5% in March 2010 to 2.2% in June 2011 with the slump in public sector settlements from 2% to 0.8%. The XpertHR Salary Survey (June 2011) forecast private sector pay settlements at 2.5% over the following year. The Staff Side also pointed to comparisons to May 2011 which showed that average earnings growth in health had dipped below the public sector in the previous year and had fallen from 4% in February 2010 to 1% in May 2011. HM Treasury forecasted average earnings growth for 2011 at 2.5% and at 3% in 2012.
- 3.35 The Staff Side felt that the £250 increase for staff earning £21,000 or less had made a small contribution to cushioning the impact for lower paid staff. However, they concluded that inflation for the low paid was running even higher than RPI inflation, that private sector settlements were surging ahead of the public sector and that NHS average earnings growth was falling behind general public sector rates.
- 3.36 **UNISON** emphasised the massive and increasing gap between NHS wages growth and inflation which would be further exacerbated by implementation of the planned pay freeze for staff earning over £21,000. UNISON considered large increases in transport, childcare and food costs looked to exert further downward pressure on NHS wages over the next financial year. It suggested that the lowest earners in the NHS had seen the biggest rise in costs over the last year and that the real value of NHS wages were at 2000 levels. It added that private sector settlements had tripled in value and public sector settlements had reduced by more than half in the year to June 2011.
- 3.37 **Unite** commented that, contrary to Government claims, cuts to public services did not lead to economic growth and new jobs in the private sector but undermined public services and reduced demand in the economy. It considered that the economy was stagnating and that these cuts could push the economy back into recession. It pointed to an analysis by Incomes Data Services that raised concerns about the pay comparisons the Government had used to claim that public sector workers were overpaid compared with those in the private sector. Unite also highlighted that IDS had consistently reported higher private sector pay rises than the public sector and that the imposition of a pay freeze was a pay cut in real terms against inflation.
- 3.38 **UCATT** commented that low paid workers continued to suffer from exceptionally high rates of inflation. Building craft workers continued to see standards of living fall while wages stagnated and demand for their skills grew in the private sector. Other costs disproportionately affected low paid workers such as fuel, heating, and energy prices. UCATT added that pay in the private construction sector easily outstripped the public sector.

Funds Available to the Health Departments

3.39 This section sets out the parties' evidence on the funds available to the Health Departments as announced in the Spending Review 2010¹⁴.

Evidence from the Parties

The Health Departments

- 3.40 The UK Government's evidence commented that the Coalition Government inherited one of the most challenging financial situations in the world and that its proposals for this year's uplift must be seen in that light. The UK Government's top priority was and must continue to be the reduction of an unsustainable structural deficit. Its strategy necessarily involved tight control of public spending including pay which represented around 50% of departmental resource budgets in England. The UK Government viewed the public sector pay freeze as being set at a time when the budget deficit was at an unprecedented post-war peak reaching 11% of GDP in 2009/10. It considered that, faced with an unprecedented deterioration in the public finances, consolidation was necessary to reduce risks in the short term, restore private sector confidence and underpin sustainable growth. The 2011 Budget reaffirmed plans to eliminate the structural budget deficit over the course of the Parliament with it forecast to fall from 7.9% of GDP in 2011/12 to 1.5% in 2015/16.
- 3.41 The **Department of Health** commented that the NHS had received a "better" Spending Review settlement than many other parts of the public sector, including a guarantee of real terms increases in each year of this Parliament, but NHS resources would be under considerable pressure. The Department would need to deliver quality and productivity savings of up to £20 billion by 2014/15 to cope with demographic increases in demand, fund the increased cost of non-pay inputs, and meet the cost of introducing new medical technologies and procedures. The evidence reiterated the UK Government's determination to deliver these savings and that funds released would be reinvested in front line services. In oral evidence, the Department added that savings worth £19 billion would be achieved through Quality, Innovation, Productivity and Prevention plans with savings worth £4.3 billion in 2010/11 and planned savings of £5.9 billion in 2011/12.
- 3.42 The Department noted that the funding available to the NHS was extremely tight compared with the recent past and, in such circumstances, increases in pay would reduce the funds available to service developments and activity growth and reduce the derived demand for staff. It added that the level of non-discretionary demand-led pressures meant that the continuation of pay drift and pay proposals for those earning £21,000 or less might impact adversely on staffing levels. The Department summarised cost pressures as: baseline pressures – the first call on NHS resources, including the pay bill; underlying demand – which had grown on average by 2.7% per annum in the last 10 years; and service developments – covering commitments to improve quality.
- 3.43 The Department provided details of NHS revenue since 2000/01 (see Table 3.1) and commented that the NHS saw large increases in funding between 2000/01 and 2010/11 with an average real terms growth in revenue expenditure of 5.3% per year.

¹⁴ HM Treasury (October 2010), *Spending Review 2010*. Available at: http://cdn.hm-treasury.gov.uk/sr2010_complereport.pdf.

Table 3.1: NHS revenue since 2000/01

Year		NHS Revenue Expenditure (£bn)	Cash growth (%)	Real growth (%)
2000/01	Outturn	42.7		
2001/02	Outturn	47.3	10.8	8.4
2002/03	Outturn	51.9	9.8	6.4
2002/03	Outturn (rebased)	55.4		
2003/04	Outturn	61.9	11.7	8.8
2004/05	Outturn	66.9	8.1	5.2
2005/06	Outturn	74.2	10.9	8.9
2006/07	Outturn	78.5	5.8	2.4
2007/08	Outturn	86.4	10.1	7.0
2008/09	Outturn	90.7	5.0	2.2
2009/10	Outturn	97.8	7.8	6.1
2009/10	Outturn (aligned)	95.6		
2010/11	Outturn (aligned)	98.9	3.4	0.5
2011/12	RDEL	102.6	3.1	0.2
2012/13	RDEL	105.2	2.5	0.0
2013/14	RDEL	108.2	2.8	0.1
2014/15	RDEL	111.1	2.7	0.0

- (1) Expenditure figures from 2000/01 to 2002/03 are on a Stage 1 resource budgeting basis.
- (2) Expenditure figures from 2003/04 to 2008/09 are on a Stage 2 resource budgeting basis, this means cost of capital and cost of new provisions are included in the RDEL.
- (3) Expenditure figures from 2010/11 are on an aligned basis. Aligned means that cost of capital is no longer included in RDEL and new provisions are included in Annually Managed Expenditure rather than RDEL.

Source: Department of Health.

3.44 The Department also provided details of the proportion of revenue expenditure consumed by the pay bill (Table 3.2). It commented that between 2000/01 and 2009/10 increases in pay bill prices had on average accounted for 28.3% of the cash increases in NHS revenue expenditure. Pay accounted for 45% of NHS revenue expenditure on average between 2001/02 and 2009/10. The Department considered that, as pay represented such a large proportion of the NHS budget, managing the pay bill was key to coping with the future slow-down in NHS funding growth. The Department provided indicative dispositions of expenditure components for 2012/13 which included assumptions of pay drift at 1% for Hospital and Community Health Services (HCHS) staff, the pay freeze and a £250 pay uplift for those earning £21,000 or less. Its estimated pay proposals would cost approximately £615 million (or one quarter) of the extra available resources.

Table 3.2: Increase in revenue expenditure and proportion consumed by pay bill

	Revenue increase (cash) (£bn)	Pay bill increase (cash) (£bn)	% of revenue increase on pay bill	% of revenue increase on pay bill prices	% of revenue increase on pay bill volume
2001/02	4.6	2.4	51.4	31.6	19.8
2002/03	4.6	2.4	51.1	25.1	26.0
2003/04	6.5	2.6	40.9	20.7	20.1
2004/05	5.0	4.5	90.6	65.1	25.4
2005/06	7.3	2.5	34.4	20.4	14.1
2006/07	4.3	1.3	30.2	42.1	-11.9
2007/08	7.9	1.3	16.3	18.5	-2.1
2008/09	4.4	2.6	59.8	27.6	32.3
2009/10	7.1	2.7	38.6	10.8	27.8
2010/11	3.3	1.6	48.5	37.3	11.2
Average	5.5	2.4	46.2	29.9	16.3

Source: Department of Health.

3.45 In supplementary evidence, the Department of Health provided data on historical pay drift for HCHS staff (Table 3.3) showing average pay drift to 2009/10. Data for 2010/11 were not yet available.

Table 3.3: Historical HCHS pay drift calculations 1997/98 to 2009/10

	HCHS paybill (£bn)	FTEs based on Sept census	Paybill per FTE (£)	Change in paybill per FTE vs last yr	Weighted average basic pay settlement	Implied paydrift Change in paybill per FTE growth vs prev yr minus weighted average basic pay settlement	Implied paydrift adjusted for estimated impact of pay reform
1997/98	15.6	755,843	20,592				
1998/99	16.5	765,949	21,507	4.4%	3.6%	0.9%	0.9%
1999/00	17.9	782,106	22,945	6.7%	5.3%	1.4%	1.4%
2000/01	19.6	801,493	24,436	6.5%	3.3%	3.2%	3.2%
2001/02	22.0	837,196	26,219	7.3%	3.7%	3.6%	3.6%
2002/03	24.3	882,114	27,576	5.2%	3.6%	1.6%	1.6%
2003/04	27.0	928,059	29,057	5.4%	3.2%	2.1%	2.1%
2004/05	31.5	968,435	32,528	11.9%	3.1%	8.8%	6.9%
2005/06	34.0	999,116	34,045	4.7%	3.2%	1.5%	-0.3%
2006/07	35.3	985,066	35,848	5.3%	2.4%	2.9%	1.5%
2007/08	36.6	980,621	37,329	4.1%	1.9%	2.2%	1.0%
2008/09	39.2	1,017,796	38,530	3.2%	2.6%	0.6%	0.3%
2009/10	42.0	1,068,818	39,258	1.9%	2.2%	-0.3%	-0.3%

Source: Department of Health.

- 3.46 The Department added that recent data on historical pay drift suggested that the historical assumption did not effectively predict future pay drift thereby prompting an overhaul of pay bill monitoring and forecasting. The Department told us that its new approach would be more timely and included improvements that will: consider average workforce levels over the year (rather than a September snapshot); allow detailed disaggregation of pay bill growth into its component drivers (including by staff group); and support a more bottom up approach to forecasting. The interim findings from the new approach suggested overall pay drift in the order of 0.5% to 0.75% in 2009/10 and 2010/11 for HCHS staff. The difference between the old and the new approach largely reflects the use of average workforce levels over the year. The Department stated that a 1% pay drift figure was a reasonable and prudent assumption for financial planning although it would be reviewed and refined as the new approach was finalised.
- 3.47 The **SGHSCD** commented that it faced challenges in a period of reduced funding while demand for services continued to increase alongside higher expectations of service quality. The health budget had received the full health revenue Barnett consequentials which had lifted the resource budget by 2.3% to £11 billion in 2012/13 although capital budgets had reduced significantly. NHS boards would have around 1% additional cash funding in 2012/13 to meet pay and non-pay pressures but NHS boards forecasted that they would need to make savings of 3.7% in 2011/12 to ensure financial breakeven. Considerable budget pressures were expected from an ageing population, new technology and the cost of drugs. The SGHSCD estimated the cost of applying the £250 uplift would be some £16 million.
- 3.48 The **Welsh Government (WG)** told us that the Health and Social Services budget had been protected in cash terms for the period 2011/12 to 2013/14. The WG estimated unavoidable NHS cost pressures at between 4 and 5% per annum for 2011/12 and 2012/13. Therefore, to remain in financial balance, NHS organisations would need to deliver cash-releasing efficiency savings of at least 5% per annum to fund these costs as well as other national or local service pressures. Most NHS organisations had carried forward an underlying deficit from 2010/11 although efficiency savings achieved equated to just over 5% of their allocation. The WG estimated that the financial gap to be bridged was approximately £1 billion by 2014/15.
- 3.49 The **DHSSPSNI** informed us that budget allocations were agreed by the Executive and ratified by the Assembly in March 2011. While the cash uplift for Health, Social Care and Public Safety Services between 2010/11 and 2014/15 was 8.3%, this represented a real terms decrease of 2.7% over the same period. The DHSSPSNI commented that there was a material and widening gap between the resources available and the best estimate of the minimum costs of maintaining existing Health and Social Care services broadly comparable to the status quo. Underlying the minimum cost estimates for 2012/13 was £196 million of inescapable cost pressure arising from Ministerial commitments, demographic change, organisational restructuring and anticipated pay bill increases (estimated at £29 million). There was no allowance within the budget for pay inflation, except for staff earning £21,000 or less and costs for incremental progression, without impacting directly on patient care.

NHS Employers

- 3.50 **NHSE** said that the NHS would need to achieve unprecedented levels of efficiency savings of up to £20 billion before 2014/15 to meet growing demand. In this context, employers were increasingly concerned that the present national pay and conditions arrangements were not affordable and that restraining pay bill costs was essential to minimise potential job losses and protect services.

- 3.51 NHSE added that the increase in the NHS budget for the period 2011/12 to 2014/15 assumed reductions in management costs and productivity gains would release up to £20 billion which could be reinvested in front line services. NHSE cited the Centre for Workforce Intelligence's research¹⁵ which asserted that large cuts to administrative and managerial staffing could make a modest contribution to savings, but the most significant savings can be achieved by increasing the productivity and efficiency of existing resources.
- 3.52 NHSE pointed to the King's Fund estimate that the £20 billion efficiency savings represented a productivity gain of between 4 and 5% per year and that the payment by results tariff assumed a 4% efficiency saving over 2011/12. In addition, a Health Service Journal survey in April 2011 found an average 6% target and Monitor estimated that NHS foundation trusts were aiming at a 4.4% reduction in operating costs in 2011/12. NHSE reported that some foundation trusts had indicated their cost improvement plans included significantly higher savings of up to 9%. NHSE provided details of a sample of ten NHS foundation trusts' plans showing savings against reductions in full time equivalent posts. They also presented the results of a NHS Confederation Members' Survey in June 2011 providing chief executives' and chairs' views on the serious financial challenges.
- 3.53 NHSE commented on unavoidable pressure on NHS finances from increasing demands for new technology, structural reform and productivity. They cited the Department of Health impact assessment which put the total costs of the changes required by the *Health and Social Care Bill* to be between £1,001 million and £1,478 million predominantly to be incurred in 2011/12 and 2012/13. Employers told NHSE that they were concerned about protecting front line services and about constraining pay costs within the tariff particularly in the light of the in-built incremental cost which was accentuated by current low turnover.
- 3.54 NHSE considered that the affordability of increases in earnings continued to dominate the thinking of employers in the NHS in England. In employers' view, the pay freeze would not be sufficient to restrain pay bill growth and employment costs and further cost reductions were required to protect jobs. NHSE added that cost pressures from increased earnings from whatever source would not be affordable and savings would need to be found elsewhere from efficiencies or reductions in service or both. NHSE estimated that the incremental pay provisions in the AfC Agreement added around 2% to the pay bill of NHS organisations in 2011/12 with a similar increase in incremental provision intended for 2012/13. The £250 uplift added a further 0.4% to the pay bill for non-medical staff.

Staff Bodies

- 3.55 The **Staff Side** told us that there were mounting cuts to both services and jobs across the UK. Funding for the NHS in England was to increase in real terms by just under 0.1% per year until 2015 but with a target of £20 billion efficiency savings. NHSScotland faced a real terms cut of 3.3% by 2011/12, Northern Ireland a real terms cut of 2.6% by 2014/15 and Wales a cumulative cut of 8.3% by 2012/13. The Staff Side felt that reduced budgets were hitting staff through redundancies, vacancy freezes, down-banding, restructuring and delayed recruitment.
- 3.56 The Staff Side pointed to the NHS in England recording a surplus of almost £1.5 billion in 2010/11, or 1.5% of NHS resources, and the cumulative value of £7 billion over the last five years. The collective position of foundation trusts was less transparent but data provided to the House of Commons indicated that they enjoyed a further £669 million surplus between 2007 and 2009. In Scotland in 2009/10 the NHS recorded a £42 million

¹⁵ Centre for Workforce Intelligence (8 July 2011), *Nursing & Midwifery Workforce Risks and Opportunities*. Available at: <http://www.cfw.org.uk/intelligence/projects/workforce-risks-and-opportunities-nursing-and-midwifery>.

surplus on its Departmental Expenditure Limit with none of the 22 health boards registering a deficit. The three NHS trusts in Wales recorded a small surplus of £126,000, the seven health boards registered a surplus of £451,000 and no trusts or health boards recorded a deficit for 2009/10. Northern Ireland recorded a deficit of £109 million.

- 3.57 The Staff Side concluded that the NHS had managed its resources effectively to stay well within budget. However, they considered that the financial challenges were not down to the service's costs but the political decision to impose a budget on the NHS for the next three years that fails to meet the level of anticipated demand. The Staff Side added that further increases in inflation meant that the Government's funding now represented a cut in the NHS budget in real terms. The Staff Side estimated incremental progression accounted for 1.4% of the total pay bill (based on UNISON's calculations in its 2010 evidence). A £250 increase for those earning £21,000 or less would add 0.3% to the NHS pay bill bringing the total pay related pressure to 1.7% – well below the 2.65% annual increase in the NHS budget.
- 3.58 **UNISON** also analysed the financial position and concluded that a certain level of accumulated reserves had been built up by trusts and health boards. Given the financial restrictions being placed on the service, UNISON considered that increases in the pay bill due to incremental pressures were well within the allocated budgetary rises and must be seen in the context of a likely squeeze on the scale of the workforce along with its associated pay bill costs.

Recruitment and Retention

Evidence from the Parties

- 3.59 The following summarises the main conclusions of the parties in their evidence as they relate to recruitment and retention including, where identifiable, specific aspects relating to AfC staff earning £21,000 or less.
- 3.60 The **Department of Health** stated that:
- The recruitment and retention position remains very healthy – both among staff earning basic salaries of £21,000 or less, and across the NHS more generally;
 - Supply and demand for non-medical staff groups is broadly in balance;
 - The NHS experienced no difficulty in meeting its requirement to increase the total non-medical workforce in England by 0.2% to 1,170,576 (headcount) in 2010; and
 - Scores in the NHS Staff Survey for job satisfaction remained consistently high and increased in 2010 although staff intention to leave has worsened between 2009 and 2010.
- 3.61 The Devolved Administrations highlighted the following:
- The **SGHSCD** commented that the Scottish Government had a commitment to no compulsory redundancies in the NHS and that vacancy rates were at historically low levels in Scotland;
 - The **WG** were seeking to change the overall AfC staff profile as multi-professional team working increases – there were too many staff in Bands 2, 5 and 6 and too few in Bands 3 and 4; and
 - The **DHSSPSNI** commented that in Northern Ireland the non-medical workforce reduced by 1.1% between 2009 and 2010. Northern Ireland NHS vacancy rates had risen across most occupational groups.

3.62 **NHSE** remarked that, for Bands 1-4, employers reported reductions in turnover since 2007, fewer long term vacancies in the wider job market and NHS pay remaining competitive with other sectors. In general, NHSE believed that the recruitment and retention position across the NHS had improved. NHSE added that non-medical FTE staff numbers fell by 1.6% in the year to May 2011.

3.63 The **Staff Side** commented that:

- Future shortages in key elements of the NHS workforce were highlighted by the latest figures on commissioning;
- It was of great concern that the NHS Information Centre had not produced revised figures for turnover and vacancy in the NHS for 2011. Without this data, the Staff Side pointed to the difficulty of identifying risks that accrue in relation to future gaps in the workforce and the difficulty in mitigating these risks through effective commissioning of relevant healthcare education;
- An ageing NHS nursing and midwifery workforce was apparent. In 2004, 9.2% of all nurses and health visitors were aged over 55 and that figure had grown every year to 2009, when it stood at 12.8%. Similarly, 40% to 45% of the midwifery workforce would reach retirement age in the next ten years; and
- Surveys undertaken by individual trade unions indicated that morale was falling year-on-year among staff. The main factors that kept staff attached to the NHS, such as commitment to their job, enjoyment of their job and the pension scheme, had all weakened in the estimation of staff.

3.64 Specific comments and data on recruitment and retention issues provided by individual staff organisations can be found in the evidence on their websites (see Appendix E).

Parties' Proposals for AfC Staff Earning £21,000 or Less

3.65 In his letter of 20 June 2011, the Chief Secretary to the Treasury identified the scope of our remit to make recommendations in respect of staff earning £21,000 or less in the following terms:

- Determined on the basis of basic salary of a full time equivalent employee, pro-rated on the basis of the hours worked, using the standard number of hours per week for that organisation;
- Part time workers with a full time equivalent salary of less than £21,000 should receive a pro-rata increase on the basis of the number of hours worked;
- The £21,000 was based on the normal interpretation of basic salary and did not include overtime or any regular payments such as London weighting, recruitment or retention premia or other allowances.

3.66 We were also informed that in considering our recommendations we might want to consider:

- The level of progression pay provided to the workforce;
- Affordability;
- The potential for payments to be more generous for those on the lowest earnings; and
- How best to avoid "leapfrogging" of those earning just under £21,000 with those earning just over £21,000, potentially through the use of a taper.

Evidence from the Parties

The Health Departments

- 3.67 The **Department of Health** strongly believed that there was no need to give these staff (earning £21,000 or less) an annual increase in excess of £250 in 2012/13. It considered that this level of uplift was appropriate to protect those on low incomes. A flat rate £250 increase represented a recurrent and pensionable pay increase of between 1.2% and 1.8% and would add £125 million to the pay bill. The Department considered a flat £250 increase would be the most simple, fair and equitable approach. It added that this approach avoided leapfrogging and any recalibration of the system which might be necessary to address the proximity of the pay points might be carried out following the end of the pay freeze. The Department estimated that, at September 2010, approximately 350,000 full time equivalent AfC staff earned £21,000 or less – around 450,000 in headcount terms – representing around 40% of non-medical staff.
- 3.68 The **SGHSCD** considered that the 2012/13 uplift for NHS staff earning £21,000 or under should be a flat rate of £250. For NHSScotland AfC staff, a £250 flat rate increase for those currently earning less than £21,000 would equate to a percentage increase of between 1.2% and 1.8%. In 2011/12, there were an estimated 46,000 whole time equivalent staff earning less than £21,000 who would qualify for the £250 flat rate uplift. This equated to 40% of all AfC staff and the estimated cost of applying the £250 uplift in Scotland would be £16 million.
- 3.69 The SGHSCD would also continue to apply the Scottish “living wage” to NHS pay scales. This was currently set at £7.15 per hour for staff undertaking a 37.5 hour week and the Scottish Government had already made a commitment to the lowest paid by uplifting it to £7.20 from 1 April 2012. The SGHSCD added that this policy could continue to be implemented in NHSScotland without affecting the architecture of current AfC pay scales.
- 3.70 We note the intention to uprate the Scottish “living wage” and ask that SGHSCD keep us informed of further uprating and any implications for the AfC pay structure.
- 3.71 The **WG** agreed with the arguments put forward by the Department of Health and believed it would be appropriate for a flat rate increase of £250 to be awarded to NHS staff in Wales earning less than £21,000 for 2012/13.
- 3.72 The **DHSSPSNI** stated that there was no flexibility to afford pay costs except the increases of £29 million identified without impacting on patient care. It added that £11 million of this funding had been provided for the minimum increase of £250 for staff earning less than £21,000 and the remaining £18 million was the estimated cost of incremental progression. AfC staff numbers earning a full time equivalent of £21,000 or less were 27,160.

NHS Employers

- 3.73 **NHSE** commented that a £250 increase for lower paid staff added around 0.4% to the pay bill. They calculated that staff earning £21,000 or less would receive increments worth around 3.3% in 2012/13 and that 36% of the non-medical workforce earned under £21,000 and 64% of these would receive incremental increases of between 1.8 and 3.7%. NHSE added that compression between pay points 15 and 16 would have to be considered following the pay freeze.
- 3.74 NHSE concluded that there were no labour market problems affecting the under £21,000 group and no evidence to support a recommendation above the minimum flat rate of £250.

Staff Bodies

- 3.75 The **Staff Side** informed us that the £250 award for the lowest paid NHS staff had gone some way to cushioning the impact of rising inflation but that evidence showed that inflation was running at a higher level for the lower paid. This was combined with benefit and welfare cuts which were detrimental to low income working households, particularly those with children. The Staff Side believed that the £250 uplift, for those sections of the workforce not covered by the pay freeze, was not sufficient.
- 3.76 The Staff Side highlighted that if the outcome of this year's pay round was a £250 rise for staff earning £21,000 or less and a pay freeze for others, the difference between points 15 and 16 would be £122. Whilst the average gap between pay points was 3.6%, the increase between points 15 and 16 would be worth 0.6%. The Staff Side drew our attention to the potential for disparities within the NHS pay system and requested that we review this situation.
- 3.77 **UNISON** recommended an increase in the minimum wage within the NHS to bring it into line with the Rowntree Foundation Minimum Income Standard¹⁶ of £7.67 per hour. UNISON believed that staff need a 5.5% uplift for earnings at the bottom of the pay scale to keep up with inflationary pressures.
- 3.78 UNISON argued that if the outcome of this year's pay round was the same as last year the difference between pay points 15 and 16 would be eroded to a nominal £122. The average gap between pay points was 3.6% whereas the increase between points 15 and 16 would be worth 0.6%. UNISON therefore suggested that staff at point 16 be awarded £250 (leaving the gap worth 1.8%) and staff at point 17 be awarded £125 to smooth the differential.
- 3.79 The **Royal College of Midwives** was pleased that maternity support workers (Bands 2-4) would be considered for an annual pay uplift this year. It stated that, while the £250 uplift was preferable to a pay freeze, both CPI inflation and RPI inflation were higher than the percentage increase to pay, therefore the value of pay still decreased for those employees. It was concerned that the pay freeze would decrease the difference between pay point 15 and 16.
- 3.80 **Unite** asked us to recommend an uplift that was at least in line with RPI inflation increases for those earning up to £21,000.

Our Comments and Recommendation

- 3.81 Our remit on basic pay for this report is confined to recommending on AfC staff paid £21,000 or less. This remit only provides us with a narrow range of considerations whereas in usual circumstances our standing terms of reference allow us to take into account a full range of considerations.
- 3.82 We note that the Chief Secretary to the Treasury's letter invited us to consider the UK Government's view that the uplift for those earning £21,000 or less should be at least £250. However, the Department of Health strongly believed that there was no need to give these staff an annual increase in excess of £250. Similarly, the Devolved Administrations considered a flat rate increase of £250 was appropriate. In contrast, the Staff Side argued that a £250 uplift was not sufficient and that higher awards were needed to keep pace with inflation. We acknowledge that the £250 increase and its application to those earning £21,000 or less were matters of judgement for the UK Government and the Devolved Administrations.

¹⁶ Available at: http://www.minimumincomestandard.org/2011_update.htm.

- 3.83 We make our assessment of the level of uplift for those earning £21,000 or less against the four factors we were invited to consider by the Chief Secretary to the Treasury. First, we were invited to consider the level of progression pay provided to the workforce. We have commented in previous reports that incremental progression is a separate issue to basic pay and that continues to be our position.
- 3.84 NHSE and the Health Departments cited that around two-thirds of AfC staff earning £21,000 or less had not reached the top of their pay bands and would therefore be entitled to receive incremental progression of between 1.8% and 3.7%. NHSE estimated that the cost of incremental pay provision added 2% to the non-medical staff pay bill. However, we note the Department of Health's interim findings from its new approach suggested overall pay drift in the order of 0.5% to 0.75% in 2009/10 and 2010/11 for Hospital and Community Health Services – the reduction in estimated pay drift from the old approach largely reflects the use of average workforce levels over the year. We welcome the Department's more refined approach to quantifying pay drift as a useful contribution to understanding pay progression and other pay costs. These data feed into our considerations of affordability and therefore greater precision in the evidence is helpful.
- 3.85 Second, affordability was a key concern in the evidence from the Health Departments and NHSE. We note that the Department of Health had received a "better" Spending Review settlement than many other parts of the public sector although available NHS funding was extremely tight. The Devolved Administrations also commented on cost pressures from financial constraints and the need to achieve efficiency savings. We accept that affordability of pay awards is impacted by growing underlying demand for services, costs associated with service developments and the need to achieve significant efficiency savings of up to £20 billion by 2014/15. We also understand from NHSE that a proportion of planned efficiency savings under NHS trusts' Quality, Innovation, Productivity and Prevention plans will be driven by controlling pay bills. In our view, the NHS faces challenges in meeting these savings while improving productivity and efficiency from existing resources.
- 3.86 Third, we received no evidence from the Health Departments or NHSE on the potential for payments to be more generous for those on the lowest earnings. They argued that there were no grounds for an award in excess of a flat rate £250. While the Staff Side commented on the impact of inflation on the lower paid more generally in their evidence, they did not present specific proposals for differentiation that would provide more generous payments for the lower paid. However, UNISON proposed bringing the minimum wage in the NHS in line with the Rowntree Foundation Minimum Income Standard requiring significant uplifts to the lower pay bands. We have received no evidence to support these higher uplifts or any differentiation for those earning £21,000 or less and, overall, we consider there is no justification for increases above £250 on recruitment and retention grounds.
- 3.87 Fourth, we were invited to consider how best to avoid "leapfrogging" of those earning just under £21,000 with those earning just over. We note that a £250 increase would not produce any overlap between AfC pay points and therefore, under our current remit, we conclude that there is no action to take at this stage. However, we recognise that the differential between AfC pay points 15 and 16 would narrow to only £122 with a flat rate uplift of £250. UNISON proposed smoothing the differential by increasing pay points 16 and 17 and the Department of Health and NHSE recognised that it might be necessary to address this issue at the end of the pay freeze. The anecdotal evidence from our NHS visits did not suggest staff were overly concerned about the narrowing gap although the second year of a flat rate £250 award may influence these views. We therefore ask the parties to discuss the issue in time for our next pay round.

- 3.88 The Chief Secretary to the Treasury's letter only covered these four factors and we therefore now turn to the relevant remaining factors in our standing terms of reference not covered by the specific remit. A significant influencing factor within our deliberations is the current position of recruitment and retention of AfC staff. We note that non-medical workforce numbers are reducing slightly, that generally supply and demand for non-medical staff is broadly in balance, and that turnover among AfC staff is low. Although there were concerns in the evidence about the pressures on NHS staff, there was no evidence presented by the parties on whether these are feeding through to any major recruitment and retention difficulties. We have commented throughout this report on how the absence of vacancy data in England has constrained our assessment. However, from the available evidence we continue to conclude that overall for AfC staff recruitment is healthy and retention remains stable.
- 3.89 NHS recruitment and retention must be seen in the light of prevailing economic circumstances. Economic expectations have been downgraded for 2012. While there has been some growth in private sector employment, reductions have been experienced in public sector employment. We note that further spending cuts have increased the OBR's estimates that public sector employment will reduce by 710,000 between 2011 and 2017. It should also be noted that unemployment, after being stable between mid-2009 and mid-2011, has risen significantly to 8.3% – the highest level since August 1994.
- 3.90 Also in relation to NHS recruitment and retention, we assess the position of AfC staff earnings in the UK against employees across the economy. We observe that, in 2011, AfC staff had higher median earnings than the private sector but slightly lower median earnings than the wider public sector. Growth in the median earnings of AfC staff between 2010 and 2011 was higher than the private sector and the wider public sector. However, pay settlements in 2011 for AfC staff were substantially lower than the economy-wide average but in line with the wider public sector. More generally looking at average weekly earnings, the private sector had seen modest growth at 2.0% for the three months to November 2011 with public sector earnings growth (excluding the nationalised banks) at 1.4% over the same period. We note that median pay settlements were around 2.5% throughout 2011.
- 3.91 We have commented before that we have sympathy with the Staff Side's argument on the impact of the recent period of high inflation rates, particularly on the lower paid, and that staff have had a reduction in real wages. However, this concern is not unique to NHS staff. We would also point out that our recommendations are not linked to inflation as it is only one of a range of our considerations. In this respect, we note that CPI inflation had fallen to 4.2% by December 2011 and RPI inflation to 4.8% with forecasts suggesting further falls in both measures over the course of 2012. These inflation rates do, however, remain in excess of those forecast at the time the UK Government announced its public sector pay policy in June 2010 which only aimed to protect those public sector workers earning £21,000 or less.
- 3.92 Finally, we comment in more depth on staff morale and motivation in relation to the whole remit group in Chapter 5. We note the Staff Side's concerns over a range of influences on morale and motivation including budget reductions, job security, impacts on workloads from vacancy freezes or delayed recruitment, service reconfigurations and workforce restructuring, pension changes and the NHS reforms in England. In this context, the Staff Side told us that their surveys were beginning to show evidence of declining morale. We will continue to monitor in future pay rounds.
- 3.93 Judged against all the required factors, our overall assessment is that there is no case to justify any increase above a flat rate £250 for those AfC staff earning £21,000 or less. Our deliberations must be seen in the light of constraints from the four Governments' public sector pay policies, affordability concerns within the NHS, healthy recruitment and stable retention for AfC staff, public and private sector settlements, comparisons of AfC

staff median earnings across the economy, and prevailing economic and labour market circumstances. **We recommend an uplift of £250 to Agenda for Change spine points 1 to 15 from 1 April 2012.**

Chapter 4 – High Cost Area Supplements and Recruitment and Retention Premia

Introduction

- 4.1 The Secretary of State's remit letter confirmed that the Department of Health would provide evidence, as necessary, on high cost area supplements (HCAS) and recruitment and retention premia (RRP). Our role under the Agenda for Change (AfC) Agreement requires us to consider any new cases for HCAS and national RRP.

High Cost Area Supplements

- 4.2 Our terms of reference state that we should have regard to regional/local variations in labour markets and their effects on the recruitment and retention of staff. Under AfC, high cost area supplements are in place for Inner London, Outer London and the Fringe with the supplement values based on a percentage of individuals' salary, with a minimum and maximum cash payment. The percentages, minima and maxima depend on the area, with Inner London attracting the highest supplement and the Fringe areas of London the lowest.
- 4.3 There was no evidence presented on HCAS for this report and therefore we make no recommendations for any new supplements.

National Recruitment and Retention Premia

- 4.4 In evidence for this report, we received an application for a national RRP from the Union of Construction, Allied Trades and Technicians (UCATT) relating to building craft workers. We also received information from Unite relating to pharmacists for whom we highlighted some ongoing concerns in our Twenty-Fifth Report¹. In addition, the Royal College of Midwives asked us to keep newly qualified midwives under review for a national RRP.
- 4.5 We review the evidence for each of these in later sections of this chapter. However, to ensure that the parties can present robust future evidence in support of any case for a national RRP, we summarise the provisions of the AfC Agreement and our approach as set out in our recent reports².

AfC Agreement

- 4.6 The AfC Agreement³ provides for the operation of recruitment and retention premia designed to address labour market difficulties affecting specific occupational groups but applying to posts and not to individuals. Section 5 of the NHS Terms and Conditions Handbook states that RRP apply where market pressures would otherwise prevent the employer from being able to recruit staff to and retain staff in sufficient numbers for the posts concerned. The AfC Agreement allows premia to be awarded on a national basis to particular groups on our recommendation where there are national recruitment and retention pressures. The level of payment should be specified or, where the underlying problem is considered to vary across the country, guidance should be given to employers on the appropriate level of payment. In making such recommendations we are

¹ NHSPRB (2011), *Twenty-Fifth Report*, TSO (Cm 8029), paragraph 4.44.

² NHSPRB (2011), *Twenty-Fifth Report*, TSO (Cm 8029), paragraphs 4.4 – 4.8.

³ Section 5 and Annex R of NHS Staff Council *NHS Terms and Conditions of Service Handbook (Amendment Number 24)*, Pay Circular (AforC) 3/2011.

required to seek evidence or advice from NHS Employers, staff organisations and other stakeholders. We have additionally commented on the need for joint evidence where possible.

Our Approach

- 4.7 Under the AfC Agreement, we have interpreted our role as follows: recruitment and retention premia “may be awarded **in future** on a national or local basis where there are recruitment and retention pressures, on a long or short term basis. We... may recommend national recruitment and retention premia for our... remit groups (with local differentiation as necessary to reflect geographical variation in the underlying problem)⁴.
- 4.8 In addition, we have consistently stated that proposals for any pay differentiation for specific remit staff groups would need the parties to present robust evidence and to address the following points:
- Why they consider that pay differentiation for the particular group is necessary;
 - Why they consider their objective(s) cannot be achieved by a route other than pay differentiation; and
 - Why they consider the level of any differentiation they propose, rather than a lesser amount, is appropriate to meet their objective(s)⁵.
- 4.9 We also agreed with the parties in our Twenty-Fourth Report⁶ that the term “national” in the context of the provisions of the AfC Agreement relating to RRP meant UK-wide. We did not, however, agree with the view previously presented by the Department of Health that, for a new national RRP to be recommended, we would have to be satisfied that there are problems across all employers in the UK, nor did we consider that there needs to be a recruitment and retention difficulty in all four countries⁷.

NHS Staff Council

- 4.10 At the time we submitted our Twenty-Fifth Report, the NHS Staff Council was considering a report by the Institute for Employment Studies (IES) which reviewed national recruitment and retention premia⁸. IES were commissioned by the NHS Staff Council in response to an employment tribunal judgment in *Hartley and Others v Northumbria Healthcare NHS Foundation Trust and Others*⁹. We summarised the main conclusions from the IES report and specific conclusions on pharmacists and building craft workers in our Twenty-Fifth Report¹⁰.
- 4.11 Following consideration of the IES report in March 2011, the NHS Staff Council agreed that:

⁴ Review Body for Nursing and Other Health Professions (2006), *Twenty-First Report*, TSO (Cm 6752), paragraph 4.19; also cited in NHSPRB (2009), *Twenty-Fourth Report*, TSO (Cm 7646), paragraph 3.9.

⁵ NHSPRB (2006), *Twenty-First Report*, TSO (Cm 6752), paragraphs 2.22 – 2.23.

⁶ NHSPRB (2009), *Twenty-Fourth Report*, TSO (Cm 7646), paragraphs 3.19 – 3.22.

⁷ Letter of 26 February 2009 from Nick Adkin, Department of Health, to the Office of Manpower Economics (OME).

⁸ Institute for Employment Studies (2010) *Review of National Recruitment and Retention Premia in the NHS 2010*. Available at: http://www.nhsemployers.org/SiteCollectionDocuments/NHSE_RRP_final%20report_final_ap171210.pdf.

⁹ Reserved Judgment of the Employment Tribunal, Newcastle upon Tyne, *Ms S C Hartley and Others v Northumbria Healthcare NHS Foundation Trust, Unison and other Unions, the Secretary of State for Health, NHS Confederation (Employers) Company Ltd, and the GMB*, 2009.

¹⁰ NHSPRB (2011), *Twenty-Fifth Report*, TSO (Cm 8029), paragraphs 4.10 – 4.15, 4.33 – 4.34 and 4.48 – 4.50.

- The national RRP for maintenance craft workers should cease after 31 March 2011 for all new starters, with transitional protection arrangements for two years (year one at 100% and year two at 50%) for staff in receipt of the national RRP, and a further review of the need for a national RRP in time to inform decisions at the end of the period of pay protection;
- The national RRP for chaplains should be withdrawn and replaced, where appropriate, with a local RRP. Employers should therefore review the need for this RRP and, where employers decide it should be withdrawn, transitional protection should be in line with that agreed for maintenance craft workers; and
- Employers should review the need for national RRP paid to groups under Annex R of the NHS Terms and Conditions Handbook including any need for a local RRP where thought necessary.

4.12 We wrote to the NHS Staff Council on 15 March 2011 commenting that, in our view, the requirement of the *Hartley* judgment had been fulfilled by consultation on the process for reviewing the national RRP for qualified maintenance craftspersons and technicians rather than the outcome. We affirmed that we had no role in decisions on the continuation of existing national RRP and, therefore, it was not appropriate to comment on the methodology, conclusions and recommendations of the IES report in relation to existing national RRP. We drew the Council's attention to three matters: that the review would have benefited from the greater involvement of UCATT; that we be kept informed of the proposed review of the need for a national RRP for qualified maintenance craftspersons and technicians; and that we would welcome a review of the unsatisfactory nature of the process for dealing with national RRP, particularly the division of jurisdiction between the Review Body and the NHS Staff Council.

4.13 The Joint Secretaries to the NHS Staff Council replied on 19 September 2011 noting the points we raised and, while appreciating our concerns, considered that the current arrangements for dealing with the award of national RRP provided the flexibility needed for all parties.

4.14 In evidence for this report, the Health Departments, NHS Employers and the Staff Side summarised the conclusions of the NHS Staff Council on national RRP. The Department of Health also provided helpful data on the use of "general" and "long term" RRP in England.

NHS Pharmacists

4.15 We have highlighted in successive reports the difficulties recruiting and retaining pharmacists in Bands 6 and 7. We recommended a fixed term national RRP for pharmacists in Bands 6 and 7 in our Twenty-Fourth Report¹¹. Our recommendation was rejected by the UK Government in July 2009 on the grounds that recruitment and retention varied widely across England, that the Devolved Administrations made clear a national RRP was not necessary, and that the difficulties would be best addressed by increasing supply and by using local RRP alongside local initiatives to support training and development.

4.16 In our Twenty-Fifth Report¹², while stating our intention to continue to monitor the position, we did not recommend a national RRP for pharmacists in Bands 6 and 7. We noted that our concerns in previous years regarding the shortage of pharmacists had been acted upon in other ways by the Health Departments.

¹¹ NHSPRB (2009), *Twenty-Fourth Report*, TSO (Cm 7646), paragraph 3.77.

¹² NHSPRB (2011), *Twenty-Fifth Report*, TSO (Cm 8029), paragraphs 4.40 – 4.44.

4.17 For this report, Unite initially presented evidence supporting a national RRP but revised its views in supplementary evidence in the light of the latest survey evidence. We review below the information provided from the Pharmacy Establishment and Vacancy Survey, the Migration Advisory Committee’s ‘Skilled, Shortage, Sensible’ report¹³, and the parties’ evidence.

Pharmacy Establishment and Vacancy Survey

4.18 The Department of Health commissioned the 2011 National NHS Pharmacy Establishment and Vacancy Survey (PEVS), which was conducted in May 2011. This survey allows for analysis of vacancies by AfC band, which is not possible using the Health Departments’ vacancy surveys. A 100% response rate was achieved from NHS organisations in England, Wales and Northern Ireland. Scotland did not take part in the 2011 PEVS, instead conducting its own surveys in September 2010 and September 2011 using a similar methodology to PEVS. The results of both surveys are combined in our analysis.

4.19 Summary tables showing national-level results from the PEVS since 2006 are in Tables 4.1 and 4.2. The main findings of the 2011 survey are as follows:

- The total vacancy rate in the UK in Band 6 was 10.9% in May 2011, a decrease of 5.3 percentage points (pp) since May 2010, and the lowest rate since data started to be gathered by Agenda for Change bands in 2006. The three-month vacancy rate in Band 6 was 6.7%, a decrease of 4.9pp on a year earlier;
- The total vacancy rate in Band 7 was 11.4% in May 2011, a decrease of 6.2pp since May 2010, and the lowest rate since at least 2007¹⁴. The three-month vacancy rate was 6.3%, a decrease of 5.2pp on a year earlier; and
- The total vacancy rate in the UK decreased between 2010 and 2011 in all Bands except 8d and 9. The three-month vacancy rate decreased in all Bands except 8d.

Table 4.1: Total vacancy rates for qualified pharmacists by Agenda for Change bands, May 2006-2011

Year	Participating UK countries	Total vacancy rate (%)							Overall
		Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9	
2006 ¹⁵	England, Scotland, Wales	16.8	11.0			3.6			11.7
2007	England, Wales	17.2	18.0	8.1	6.3	5.4	2.5	4.1	12.0
2008	England, Wales, Northern Ireland	22.2	16.9	10.2	8.8	6.0	2.8	1.9	13.2
2009	All UK countries	24.7	19.0	10.0	7.3	5.6	2.2	4.6	13.7
2010	All UK countries	16.2	17.6	8.6	5.2	8.1	2.4	2.0	11.2
2011	All UK countries*	10.9	11.4	5.3	3.6	4.3	2.7	2.5	7.3

* Data for Scotland relate to September instead of May.

Source: *Pharmacy Establishment and Vacancy Surveys*.

¹³ Available at:

<http://www.ukba.homeoffice.gov.uk/sitecontent/documents/aboutus/workingwithus/mac/skilled-shortage-sensible/>.

¹⁴ It is not possible to determine whether the rate in 2011 was also lower than that in 2006, as in that year data were grouped for AfC Bands 7-8b.

¹⁵ In 2006, data were presented for ‘junior’ (AfC Band 6 and Whitley grades A-C), ‘middle’ (AfC Bands 7-8b and Whitley grades D-E) and ‘senior’ pharmacists (AfC Bands 8c-9 and Whitley grades F-H) because implementation of the Agenda for Change pay system was not complete.

Table 4.2: Three-month vacancy rates for qualified pharmacists by Agenda for Change bands, May 2008-2011

Year	Participating UK countries	Three-month vacancy rate (%)							Overall
		Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9	
2008	England, Wales, Northern Ireland	14.8	10.1	6.4	4.1	2.7	2.5	1.0	8.0
2009	All UK countries	20.9	14.1	7.2	5.1	4.3	1.4	0.9	10.5
2010	All UK countries	11.6	11.5	6.3	4.0	6.4	1.1	3.5	7.9
2011	All UK countries*	6.7	6.3	3.6	2.9	3.1	1.8	0.9	4.5

* Data for Scotland relate to September instead of May.

Source: Pharmacy Establishment and Vacancy Surveys.

4.20 The reduction in vacancy rates for junior pharmacists between 2010 and 2011 reflect increases in the number of permanently employed staff in these grades, as shown in Table 4.3. A small decrease in the funded establishment (0.3% in Band 6 and 0.1% in Band 7) also contributed to the decrease in vacancy rates.

Table 4.3 Change in full time equivalent qualified pharmacists in post, by AfC Band and UK country, May 2010 - May 2011

	Percentage change in FTE pharmacists in post between May 2010 and May 2011							
	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9	Total
England	5.9	11.2	4.1	0.3	-1.0	-6.3	-4.7	4.4
Wales	-6.0	1.5	-0.7	-1.0	1.0	13.6	12.5	-0.3
Scotland*	16.5	0.8	14.1	5.6	9.9	-19.7	-1.8	8.3
Northern Ireland	3.1	-14.9	37.9	28.8	28.7	0.0	n/a	4.9
UK	6.0	7.4	5.9	1.2	0.6	-6.2	-2.4	4.5

* Data for Scotland show change between May 2010 and September 2011.

Source: Pharmacy Establishment and Vacancy Surveys.

4.21 Table 4.4 shows the latest changes in vacancy rates by 'UK region'¹⁶. In general, the national-level decreases in vacancy rates have been mirrored across regions:

- The total vacancy rate in Band 6 decreased in 11 out of 13 UK regions between 2010 and 2011, and in 2011 ranged from a low of 3.5% in Northern Ireland to a high of 30.8% in the North East Strategic Health Authority (SHA) area (the North East had the lowest total vacancy rate in this band in 2010);
- The three-month vacancy rate in Band 6 decreased in 8 out of 13 UK regions between 2010 and 2011, and in 2011 was lowest in Scotland (1.8%) and highest in North East SHA area (29.0%);
- The total vacancy rate in Band 7 increased only in Wales between 2010 and 2011, and in 2011 ranged from 6.2% in Scotland to 19.5% in the South East Coast SHA area;
- The three-month vacancy rate in Band 7 decreased in 11 out of 13 UK regions between 2010 and 2011 – increasing only in Wales and Northern Ireland – and in 2011 was lowest in Scotland (3.3%) and highest in the West Midlands SHA area (10.6%).

¹⁶ For brevity, 'UK region' denotes Scotland, Wales, Northern Ireland and each Strategic Health Authority (SHA) area in England.

Table 4.4: Staffing establishments and vacancy rates for qualified pharmacists by UK country and region

	Staffing establishment 2011 (number of funded posts)				Total vacancy rate ¹⁷ 2011 (%) (posts not permanently occupied) Comparison with 2010 survey					3-month vacancy rate ¹⁸ 2011 (%) (posts vacant for 3 months or more) Comparison with 2010 survey						
	Band 6	Band 7	Bands 8a-9	Total	Band 6 (%)	Band 7 (%)	Bands 8a-9 (%)	All bands (%)	Band 6 (%)	Band 7 (%)	Bands 8a-9 (%)	All bands (%)	Band 6 (%)	Band 7 (%)	Bands 8a-9 (%)	All bands (%)
North East	55	101	238	394	30.8 +35.0	13.4 -14.7	4.7 -4.6	10.5 -1.4	29.0 +20.1	8.3 -11.2	5.6 -1.4	9.5 -0.6				
North West	180	258	692	1,130	6.6 -11.8	18.6 -3.0	5.3 -2.8	8.5 -4.2	5.2 -10.8	8.4 -5.1	4.3 -3.2	5.4 -4.8				
Yorks & Humber	99	145	493	737	15.5 +14.6	6.7 -21.9	5.6 -2.4	7.2 -4.0	6.7 -2.8	6.2 -19.2	4.3 -1.0	5.0 -4.9				
East Midlands	78	147	295	520	7.7 -18.7	12.5 -8.0	7.5 -0.8	8.9 -5.6	2.6 -7.2	6.5 -9.1	4.4 -2.1	4.7 -4.8				
West Midlands	108	128	454	691	17.2 -3.7	17.0 -4.5	6.6 -2.5	10.2 -3.1	13.8 +0.2	10.6 -5.1	4.6 -1.4	7.2 -1.8				
East of England	116	166	367	649	12.0 -6.2	13.5 -8.2	4.5 -5.7	8.1 -6.3	9.0 +1.4	10.2 -5.0	4.1 -3.5	6.5 -3.0				
London	325	449	858	1,632	8.0 -4.1	7.9 -5.1	4.2 -3.8	6.0 -4.1	3.1 -4.0	3.5 -3.1	2.6 -3.2	3.0 -3.3				
South East Coast	86	134	264	484	7.8 -14.6	19.5 -0.7	5.7 -2.0	9.9 -3.7	2.7 -4.6	7.9 -8.1	3.2 -1.7	4.4 -3.7				
South Central	78	123	301	502	14.8 -4.8	8.0 -7.2	3.5 -1.3	6.3 -3.6	14.9 -1.8	4.5 -8.3	3.1 -1.5	5.3 -3.5				
South West	114	141	328	584	12.9 -8.6	11.1 nc	4.1 -1.4	7.5 -2.3	3.0 -16.4	5.3 -1.6	2.1 -0.4	3.1 -3.7				
England	1,238	1,793	4,291	7,322	11.4 -4.2	12.3 -6.6	5.1 -2.9	7.9 -3.9	7.0 -4.2	6.6 -6.6	3.7 -2.2	5.0 -3.5				
Wales	64	81	392	538	19.4 -2.2	13.9 +3.1	3.5 -0.2	7.0 -0.1	14.7 +3.4	9.1 +3.4	1.6 -0.1	4.3 +0.8				
Scotland ¹⁹	130	245	594	970	7.0 -18.1	6.2 -7.9	1.8 -2.5	3.6 -6.4	1.8 -18.1	3.3 -4.1	0.8 -2.4	1.6 -5.2				
Northern Ireland	86	148	154	387	3.5 -2.4	7.9 -5.2	1.9 +3.7	4.5 -2.6	3.5 nc	6.0 +2.8	1.8 -2.7	3.8 +0.1				
UK	1,519	2,267	5,431	9,217	10.9 -5.3	11.4 -6.2	4.5 -2.6	7.3 -3.9	6.7 -4.9	6.3 -5.2	3.2 -2.1	4.5 -3.3				

nc No change (change less than ±0.05 percentage points)

Source: *Pharmacy Establishment and Vacancy Surveys*.

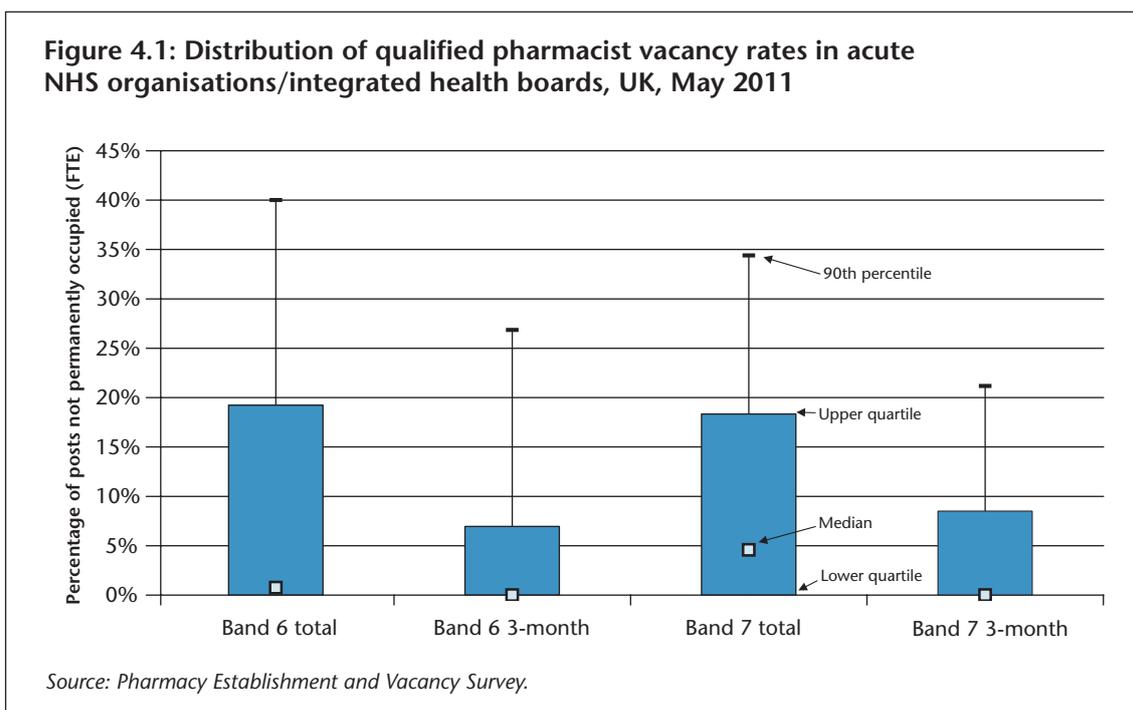
¹⁷ Calculated as establishment minus number of staff in post, divided by establishment. This gives negative vacancy rates if staff in post exceeds establishment.

¹⁸ Calculated as number of 3-month vacancies divided by establishment.

¹⁹ Scotland data refers to September 2011, and change on May 2010.

4.22 Figure 4.1 shows the distribution of total and three-month vacancy rates in Bands 6 and 7 in 2011, at organisational level²⁰:

- Half of NHS organisations had zero (or negative²¹) total and three-month vacancy rates in Band 6;
- Over two-thirds of NHS organisations had zero three-month vacancy rates in Band 7, with 44% reporting zero or negative total vacancy rates in this band;
- A small minority of NHS organisations had total vacancy rates in Band 6 and/or Band 7 in excess of 30%, with an even smaller minority reporting three-month vacancy rates above this level.



4.23 Further analysis conducted by our secretariat shows that there is no clear and consistent geographical pattern in vacancy rates across the UK: there are certain localities where vacancy rates are higher than average, adjacent to areas with zero vacancies; locations with the highest and lowest vacancy rates were spread out across the UK.

Migration Advisory Committee

4.24 We note that the Migration Advisory Committee (MAC)²² recommended that pharmacists and pre-registration pharmacists should be removed from the Shortage Occupation List in September 2011. The Government accepted MAC's recommendations in October 2011. The Committee believed that there was no compelling evidence of a labour shortage for pharmacists. It referred to evidence provided by the Centre for Workforce Intelligence (CfWI) which reported that the NHS continues to lose pharmacists to the community sector with some areas of the UK reporting retention rates as low as 49% for

²⁰ Primary care trusts in England are omitted from this analysis, as the vast majority do not have established posts in Bands 6 or 7.

²¹ Negative vacancy rates are possible if the number of staff in post exceeds the funded establishment.

²² Migration Advisory Committee (September 2011) *Skilled Shortage Sensible*. Available at: <http://www.ukba.homeoffice.gov.uk/sitecontent/documents/aboutus/workingwithus/mac/skilled-shortage-sensible/skilled-report.pdf?view=Binary>.

pre-registration trainee pharmacists in the NHS. The CfWI also suggested to MAC that the high proportion of locum pharmacists related to a lifestyle choice whereby they had more ability to work flexibly if they wished.

- 4.25 The Migration Advisory Committee suggested that a recruitment and retention premia could assist in attracting these pharmacists to NHS posts if there continued to be a shortage.

Evidence from the Parties

The Health Departments

- 4.26 The **Department of Health** continued to believe that no national RRP is necessary for junior pharmacists in Bands 6 and 7. The UK Government had taken actions to improve recruitment and retention including the formation of the *Pharmacists Numbers Task and Finish Group*, introduction of the *Modernising Careers Programme* and the flexibility for employers to use local RRP where appropriate. The UK Government believed that these actions continued to improve the recruitment and retention position for junior pharmacists. In supplementary evidence, the Department highlighted the general improvement in vacancy rates in Bands 6 and 7, against a background of stable or increasing establishment. The Department told us that, despite concerns that the number of posts at risk or dis-established had increased since the survey, its informal feedback from SHA workforce planning directors indicated that the position had not changed between May and October 2011. The Department added that retention of newly registered pharmacists completing their training in the NHS was stable in 2010 at 65% compared with 64% in 2009.
- 4.27 The **WG** commented that in Wales the NHS pharmacist vacancy rate was at 7% and the NHS continued to have recruitment difficulties due to competition from the community sector. In 2011, Band 6 pharmacists had a vacancy rate of 19.39% in Wales. Training posts had been cut in response to the current financial climate. The Welsh Government informed us that increasing student debt and the need to earn more money were cited as reasons for leaving the NHS and moving to community pharmacy posts.
- 4.28 The **SGHSCD** told us that pharmacist vacancy rates in Scotland, while still higher than other staff groups, had reduced considerably and that local RRP continued to remain an option for health boards encountering difficulties.
- 4.29 The **DHSSPSNI** stated that there was no current evidence to support a national RRP for Band 6 and 7 pharmacists. The vacancy situation for junior pharmacists continued to improve because of the greater availability of the pharmacist workforce, continued supply from the university sector, less movement in the public sector and fewer new posts being created.

NHS Employers

- 4.30 **NHSE** told us that employers were not persuaded of the need for a pharmacists' national RRP. They continued to be of the view that a national approach would be unlikely to resolve pharmacy recruitment problems or represent value for money. It would also place additional financial pressure on NHS organisations. Employers considered that the recruitment and retention situation of pharmacy staff had improved.

Staff Bodies

- 4.31 The **Staff Side** advised that there continued to be a need to address shortages in the pharmacy workforce and believed that the previous recommendation made by NHSPRB in 2009 for a national RRP should have been implemented by the Government.

- 4.32 The Staff Side stated that this position was supported by the July 2011 Centre for Workforce Intelligence report into the pharmacy workforce which suggested that "... recruitment and retention mechanisms are researched and established in order to retain a greater number of Band 6 staff". The Staff Side considered that this emphasised that the problem of staff shortages for the pharmacy workforce had not been dealt with and a national RRP was needed.
- 4.33 **Unite** commented that provisional survey results on pharmacy posts showed there was a reliance on locum and agency staff to deliver pharmacy services. Unite stated that it would be more cost effective to implement a national RRP therefore increasing the number of employed staff rather than continue to pay large fees to agencies. In supplementary evidence, Unite provided further commentary on the latest available Pharmacy Establishment and Vacancy Survey results. Unite accepted that in many places vacancy rates for pharmacists across bands had now reduced but emphasised that vacancy rates remained high in many areas of the country. In the light of the latest survey, Unite requested that we called for further monitoring of pharmacy vacancies and requested that we made a suggestion for trusts with continuing problems to use local RRP.

Our Comment

- 4.34 In our Twenty-Fourth Report we recommended a fixed term national RRP as a way of addressing the difficulties in recruiting and retaining Band 6 and 7 pharmacists. Since then, the vacancy position has changed within the NHS and we consider there is no longer a national problem relating to the recruitment and retention of Band 6 and 7 pharmacists. However, we are concerned to note that retention rates of newly qualified NHS pharmacists are not improving merely remaining stable.
- 4.35 We note that the number of vacancies for Band 6 and 7 pharmacists has decreased within the NHS according to the National NHS Pharmacy Establishment and Vacancy Survey 2011. It is also clear from the findings of the MAC report²³ that the degree of labour shortage in both the NHS and community pharmacy appears to be "negligible". We also note MAC's conclusion that NHS pharmacists' vacancies could be related to heavy workloads or preferable terms and conditions which can be found in the private sector or by working as locums.
- 4.36 We recognise that Unite's further evidence following the release of the latest statistics acknowledged that the vacancy rate for Band 6 and 7 pharmacists had decreased. Our assessment from all the evidence is that any remaining recruitment and retention issues exist only in specific localities around the country rather than on a national basis. We remind employers that they have the ability to put in place local recruitment and retention premia to address continuing vacancy problems and we would encourage them to do so where supported by appropriate evidence.
- 4.37 In the light of the latest survey evidence, our specific review of the position on pharmacist vacancies is no longer required but we ask that the parties draw our attention to evidence on the vacancy situation as appropriate.

²³ Migration Advisory Committee (September 2011) *Skilled Shortage Sensible*, paragraph 3.93. Available at: <http://www.ukba.homeoffice.gov.uk/sitecontent/documents/aboutus/workingwithus/mac/skilled-shortage-sensible/skilled-report.pdf?view=Binary>.

Proposal for a National Recruitment and Retention Premium for Building Craft Workers

4.38 We have considered proposals to introduce a national RRP for building craft workers in our Twenty-Third Report²⁴, during our monitoring of the parties' three-year pay agreement²⁵, and most recently in our Twenty-Fifth Report²⁶. UCATT has presented a renewed case for a national RRP for building craft workers.

Evidence from the Parties

The Health Departments

4.39 The **Department of Health** provided information on the estimated distribution on AfC bands, of job roles which could be categorised as building craft workers, shown in Table 4.5²⁷.

Table 4.5: Distribution of full time equivalent building craft workers by AfC band and specified job role, September 2010

Job role		AfC Band											Total	
		1	2	3	4	5	6	7	8a	8b	8c	8d		9
Building craftsperson	No	1	3	90	298	28	3	0	0	2	0	0	0	424
	%	0	1	21	70	7	1	0	0	1	0	0	0	100
Carpenter	No	0	0	50	123	13	0	0	0	0	0	0	0	186
	%	0	0	27	66	7	0	0	0	0	0	0	0	100
Building Officer	No	1	27	22	22	39	145	140	34	11	3	1	0	447
	%	0	6	5	5	9	32	31	8	2	1	0	0	100
Painter/Decorator	No	0	0	119	112	3	0	0	0	0	0	0	0	234
	%	0	0	51	48	1	0	0	0	0	0	0	0	100

Source: Department of Health.

Note: Individual items may not sum to totals because of rounding.

4.40 The Department also provided estimates of the proportion of staff in selected job roles receiving a RRP: 40% of building craftspersons were in receipt of a RRP²⁸ in June 2011, as were 18% of building officers, 32% of carpenters and 18% of painter/decorators.

Staff Bodies

4.41 UCATT highlighted the following points on NHS building craft workers:

- Mean average earnings of a private sector construction worker were £24,047 in April 2010, compared with £18,827 in the NHS at the top of Band 3, or £21,798 at the top of Band 4, and that there was an industry agreement to increase minimum rates by 1.5% from September 2011;

²⁴ NHSPRB (2008) *Twenty-Third Report*, TSO (Cm 7337), paragraphs 3.54-3.55.

²⁵ NHSPRB (2009) *Consideration of Whether to Seek a Remit to Review the Pay Increase Agreed by the Parties for 2010/11 – December 2009*, paragraphs 112-124.

²⁶ NHSPRB (2011) *Twenty-Fifth Report*, TSO (Cm 8029), paragraphs 4.45-4.60.

²⁷ The Department told us that, given there was not a universal description of the job roles in ESR, for instance a building officer could be described as an 'officer' or a 'manager', it is likely that this analysis will not represent full coverage of the staff numbers belonging to each of the job roles.

²⁸ It is not possible to determine whether these RRP are local or national.

- It was illogical, inequitable and divisive that NHS maintenance craft workers were in receipt of a national RRP while building craft workers were not which had a highly de-motivating effect and left the NHS as an uncompetitive employer;
- The workforce had an ageing profile with an average age of 56, an average length of service of over 18 years, and low numbers of young people entering the sector;
- 61% of building craft workers in separate trusts had requested, and had been refused, a local RRP, while a substantial number identified recruitment problems because of low pay;
- Previous research by the University of Greenwich remained valid and provided a clear basis for the payment of a national RRP. Local RRP were in payment across the country which demonstrated the necessity of implementing RRP on a national basis or local RRP should be permitted for all NHS building craft workers, as well as for maintenance craft workers.

4.42 UCATT commented that the withdrawal of the national RRP for maintenance craft workers had led to some employers to withdraw local RRP for building craft workers without notice or transitional protection arrangements. UCATT was challenging these decisions in employment tribunals. UCATT sought our observations on the proper manner in which local RRP should be agreed and reviewed.

4.43 UCATT also drew to our attention advice from the NHS Staff Council relating to the banding of building craft workers which recommended that “trusts review in partnership the matching of building craft worker jobs and satisfy themselves that the outcomes matched to the Band 4 profile can be justified and that the rationales are robust”. UCATT told us that, to date, they were not aware of any negative consequences for its members emanating from this exercise which, in UCATT’s view, clearly demonstrated that all building craft workers should be paid at a minimum of Band 4. UCATT, though recognising that banding issues are outside our remit, nonetheless asked us to comment on this matter.

Our Comment

4.44 We consider that UCATT’s case for a new national RRP for building craft workers is again unconvincing. UCATT has noted that building craft workers tend to have long job tenures, indicating no problems in retaining these workers; and UCATT has not demonstrated problems with recruitment.

4.45 This is the fifth year running that UCATT has raised this issue. We strongly recommend that if UCATT pursues this issue in future it bears in mind that RRP are for situations where market pressures would otherwise prevent the employer from being able to recruit and retain staff in sufficient numbers for the posts concerned as set out in Section 5 of the NHS Terms and Conditions Handbook. If UCATT seeks success it should concentrate on presenting robust and relevant evidence that shows there are widespread recruitment and retention difficulties that apply to NHS building craft workers. Our view is that UCATT failed to do that on this occasion.

4.46 We again conclude that there is no evidence to support UCATT’s case for a national RRP for building craft workers.

4.47 UCATT has drawn to our attention the withdrawal, without notice, of some existing local RRP for its members. The NHS Terms and Conditions Handbook provides clear guidance on this matter²⁹, which we suggest strongly that employers follow. We also note the NHS Staff Council's advice on reviewing the job evaluation of Band 4 building craft workers and reiterate that this is a matter for the NHS Staff Council.

Newly Qualified Midwives

4.48 In reviewing all national RRP, the IES 2010 report³⁰ to the NHS Staff Council advised that, while no national RRP were recommended, the position for some groups should be kept under review including for newly qualified midwives. In evidence for our report, the Royal College of Midwives asked us to keep newly qualified midwives under review for a national RRP and we therefore review the evidence presented below.

Evidence from the Parties

Staff Bodies

4.49 The RCM commented on the shortages of midwives in England and Wales, according to its Birthrate Plus methodology, and that the shortages occurred across every Strategic Health Authority. The RCM summarised the issues affecting recruitment and retention of midwives as follows:

- Trusts/boards were cutting the training budgets for midwifery and maternity staff, and reviewing the skill mix in Maternity Units which would affect retention as the inability to progress would have an effect on the attractiveness of a midwifery career;
- Retention was also affected by the increasing complexity of cases, pressures to make efficiency savings, verbal and physical abuse in the workplace, the pay freeze and inflation, increasing pension contributions, and insufficient reward for obtaining professional qualifications and incurring student debt; and
- Midwifery was an ageing workforce with, according to a RCM survey, a vacancy rate of 4.8% in England and 67% of vacancies over three months old. Problems recruiting more experienced midwives were having an effect on the skill mix in units.

4.50 The RCM noted the IES report's conclusions on newly qualified midwives and asked us, in addition to keeping a national RRP under review, what guidance might be provided on local RRP where there was a long term shortage of midwives.

The Health Departments

4.51 The **Department of Health** highlighted that the White Paper *Equity and Excellence: Liberating the NHS* made commitments to extending maternity choice including the development of new provider networks. These would supersede specific commitments in the past to expand the numbers of midwives. The Coalition Agreement included a commitment to increase the number of Sure Start health visitors by 4,200 and a programme was underway to increase capacity. The *Midwifery 2020 Programme* identified key messages about new ways of working, midwives' roles and responsibilities, and

²⁹ NHS Staff Council *NHS Terms and Conditions of Service Handbook (Amendment Number 24)*, Pay Circular (AforC) 3/2011, paragraphs 5.10-5.11.

³⁰ Institute for Employment Studies (2010) *Review of National Recruitment and Retention Premia in the NHS 2010*. Published at: http://www.nhsemployers.org/SiteCollectionDocuments/NHSE_RRP_final%20report_final_ap171210.pdf.

the training and development requirements to maximise the midwifery contribution in future. SHAs were reviewing the supply of local midwives, including attrition rates from training, and were developing appropriate recruitment, retention and return strategies.

Our Comment

- 4.52 We noted in our Twenty-Fifth Report the RCM's concerns about the shortages of NHS midwives. We are grateful for the further analysis by the RCM and the Department of Health's commentary on the activity underway to manage the midwifery workforce. We consider this an issue largely of supply – specifically the accurate assessment of the numbers of midwives required, the impact of NHS reforms in England on these workforce requirements and determining the required level of training commissions. We conclude from the evidence that further action is needed to manage more effectively workforce and training planning to ensure an adequate supply of midwives in the right locations. At this stage, the evidence does not point to widespread national recruitment and retention problems which require a national pay response. However, we remind employers that, where local recruitment and retention difficulties are experienced, local RRP can be used when supported by robust evidence that a pay solution is required.

Chapter 5 – General Workforce Issues

Introduction

- 5.1 In addition to our remit for those AfC staff earning £21,000 or less, the Chief Secretary to the Treasury's remit letter also confirmed that for those workers paid above £21,000 the UK Government would provide information about recruitment, retention and other aspects of the affected workforces as appropriate.
- 5.2 We therefore review the information provided by the parties on the AfC workforce under the following headings:
- Trends in recruitment and retention;
 - Morale and motivation;
 - Workforce planning;
 - Training and development;
 - The Knowledge and Skills Framework; and
 - Data relating to our remit group.

Trends in Recruitment and Retention

- 5.3 We summarised the available evidence on recruitment and retention relating to those earning £21,000 or less in Chapter 3. From this evidence, we continue to conclude that overall for AfC staff the position on recruitment is healthy and retention is stable. In this section, we therefore review the information provided by the parties on training commissions and AfC shortage groups.

Recruitment

- 5.4 The **Staff Side** pointed to an ageing profile of the NHS workforce in England which it suggested would be worth tracking to establish whether it represented a worrying trend for the NHS in attracting younger staff. They stated that an ageing workforce had long been apparent within nursing and midwifery. They highlighted that 12.8% of all nurses and health visitors were over the age of 55 in 2009.
- 5.5 The commissioning levels for non-medical groups within the NHS were set to “plummet” between 2010/11 and 2011/12, according to the evidence submitted by the Staff Side. Anticipated commissioning rates were well below recent levels for the majority of professions, with the exception of community nursing where the increase was almost entirely driven by the commitment to increasing the number of health visitors. The Staff Side believed a short term, cost-driven “slashing” of commissioned places across almost all occupations that require professional training was at the expense of long term medical needs.
- 5.6 The Staff Side highlighted the decrease in the number of additions to the nursing workforce from outside the EU. This had occurred while there was a simultaneous increase in UK nurses migrating to work abroad.
- 5.7 The **Department of Health** reported on training commissions. The two routes into nursing had seen a switch from diploma to degree commissions and therefore there had been a rise in degree commissions and a reduction in diploma commissions by 2010/11. The Department also reported on the decrease in training commissions for allied health

professionals and healthcare scientists and technicians. However, the Department commented that, while the intake to training places was important, the key driver for future supply was the output from programmes which varied with student retention. The Department added that the number of training places to commission was, therefore, based on anticipated demand in the local health economy, recent information about student retention and levels of graduate employment.

Our Comment

5.8 We note that there is a planned drop in number of training commissions and we comment later in this chapter about our concerns over the fragmentation of the workforce planning process. While we also note that overall non-medical workforce numbers are planned to decline slightly, in our view such falls in the number of training commissions can store up potential manpower supply problems which only become evident in the future. In such cases it can be difficult to redress such shortages in supply and they can often lead to expensive pay solutions to retain experienced staff. We ask the parties to continue to monitor the number of training commissions for our remit group and report any concerns in future evidence.

AfC Shortage Groups

5.9 The Migration Advisory Committee (MAC) submitted its latest report¹ to the UK Government on 12 September 2011 recommending changes to the Shortage Occupation List. The UK Government asked the MAC in March 2011 to consider: *“in which occupation(s) or job title(s) skilled to National Qualifications Framework level 4 or above is there a shortage of labour that it would be sensible to fill using labour from outside the European Economic Area”*.

5.10 For an occupation or job title to be placed on the MAC recommended list three tests are considered:

- Whether individual occupations or job titles are sufficiently **skilled**;
- Whether there is a **shortage** of labour within each skilled occupation or job title; and
- Whether it is **sensible** for immigrant labour from outside the European Economic Area to be used to fill the vacancies.

5.11 We note that the UK Government accepted the MAC recommendations to remove the following occupations covered by our remit from the Shortage Occupation List:

- Pre-registration and registered pharmacists;
- Band 7 speech and language therapists; and
- Health Professions Council (HPC) registered orthoptists.

5.12 The specific occupations within our remit group included on the Home Office Shortage Occupation List as of 14 November 2011² were:

- Specialist nurses working in operating theatres;
- Operating department practitioners;

¹ Available at: <http://www.ukba.homeoffice.gov.uk/sitecontent/documents/aboutus/workingwithus/mac/skilled-shortage-sensible/skilled-report.pdf?view=Binary>.

² Available at: <http://www.ukba.homeoffice.gov.uk/sitecontent/documents/workingintheuk/shortageoccupationlistnov11.pdf>.

- Specialist nurses working in neonatal intensive care units;
- HPC-registered diagnostic radiographers;
- HPC-registered therapeutic radiographers;
- Biological scientists and biochemists;
- Nuclear medicine technologists; and
- Radiotherapy technologists.

5.13 MAC presented, for the first time, a list of occupations and job titles that have been on the Shortage Occupation List continuously since first recommended in 2008 – including specialist nurses working in operating theatres, operating department practitioners, HPC-registered diagnostic radiographer, therapeutic radiographer and sonographer. MAC urged the Government and employers to give serious consideration to how these persistent labour shortages could be addressed in the long term, with a view to their removal from the list.

5.14 In our Twenty-Fifth Report³ we stated that we would continue to monitor the following groups on which we summarise below the parties' information presented for this report:

- *Health visitors* – the Coalition Government's Agreement (June 2010) included a commitment to increase the number of Sure Start health visitors by 4,200 by 2015. The **Department of Health** stated that discussions had begun with the Nursing Midwifery Council and others to develop plans to improve retention, increase the number of training places and provide flexible training options. The **Staff Side** also noted that community nursing would see increased training commission places after two years of decline;
- *Midwives* – using its Birthrate Plus methodology and figures from external sources the **Royal College of Midwives** estimated a shortage of 4,664 midwives in England across every Strategic Health Authority and also estimated a shortage of 136 midwives in Wales. The **Department of Health** stated that each SHA was reviewing the supply of local midwives, including attrition rates from training, and had developed appropriate recruitment, retention and return strategies;
- *Physiotherapists* – a survey by the **Chartered Society of Physiotherapists (CSP)** of senior physiotherapy managers in the NHS across the UK showed that 54% of respondents had already experienced or expected a reduction in the number of Band 5 posts available to new graduates. The survey reported that around half of managers said some or all vacant posts were automatically cut from the funded establishment and a further 57% said some or all vacant posts were automatically frozen;
- *Radiographers* – the **Society of Radiographers (SoR)** survey of vacancy rates among sonographers showed that the vacancy rate was 10.9% across ultrasound departments. The **Staff Side** added that the main reason for vacancies were that departments were waiting for a trainee to qualify or they were unable to recruit suitable applicants. Other SoR surveys conducted in autumn 2010 showed an average three months or over vacancy rate for mammographers of 8.1% in breast screening departments and a vacancy rate of 8.4% for therapeutic radiographers;

³ NHSPRB (2011), *Twenty-Fifth Report*, TSO (Cm 8029), paragraph 5.6.

- *Orthoptists* – the **British and Irish Orthoptic Society** believed that the practice of stripping out senior posts (Band 8 and above) might look attractive but had serious consequences for quality of service, expert clinical knowledge, career progression and morale and motivation. BIOS considered that undergraduate commissioning was just about in line with vacancy levels.

Our Comment

- 5.15 Our remit for this report has allowed us to broadly scan the current position on recruitment and retention for AfC staff. We review the evidence in Chapter 3 and conclude that recruitment continues to be healthy and retention is stable. We also comment that the current position needs to be viewed in the light of prevailing economic and labour market circumstances. In this context, we note that the position for shortage groups may also be easing slightly although further monitoring is required. We also urge the Department of Health to address the long term occupational shortages raised by the MAC report.
- 5.16 In our future deliberations, we will rely on the parties to keep us informed of any pay and workforce issues related to specific shortage groups. We therefore ask that they highlight where pay plays a specific role in such groups' recruitment and retention. Often shortages can arise from weaknesses in establishing sufficient training commissions, in workforce planning, and in making available appropriate education and training. It is important to us in considering the evidence that we can clearly isolate pay from other workforce matters. The NHS Staff Surveys and individual union surveys can help in this context and we, again, stress the need for accurate and reliable data (e.g. on vacancies and skill mix changes) being available to support our pay recommendations.

Morale and Motivation

NHS Staff Surveys

- 5.17 The latest NHS Staff Survey for England was undertaken during September to December 2010 with almost 165,000 employees participating and the results were published in March 2011. The NHS Scottish Staff Survey (undertaken in October and November 2010) reported in January 2011 with 42,061 staff responding. Staff Surveys were not undertaken for 2010/11 in Wales or Northern Ireland.
- 5.18 The main conclusions from the NHS Staff Survey in England were:
- 77% of staff had had appraisals in the last 12 months (69% in 2009);
 - 64% were happy with the standard of care provided by the trust (an increase from 62% in 2009);
 - 41% have had good opportunities to develop in their work (compared with 44% in 2009);
 - 28% said that they will look for a new job in the next 12 months (up from 22% in 2009); and
 - 8% reported experiencing physical violence from patients, relatives or other members of the public, while 15% said they have been subject to bullying, harassment and abuse.

- 5.19 The 2011 NHS Staff Survey in England will run between September and December 2011 with nationally aggregated data available in late March 2012. The NHS Scottish Staff Survey is undertaken biannually and will be next undertaken in 2012. The next Health and Social Care Staff Survey in Northern Ireland is expected to take place in late 2011 or early 2012.

The Health Departments

- 5.20 The **Department of Health** commented that the intention of staff earning £21,000 or less to leave the NHS had worsened between 2009 and 2010 from 2.52 to 2.62 (on a scale of 1-5 where 5 is highest). Figures had worsened very slightly for all staff groups except nurses, where intention to leave had stayed the same. The Department highlighted that the score for job satisfaction had remained consistently high and increased again in 2010 and was the highest it had been in the last five years.
- 5.21 The Department commented that the opinion of staff earning less than £21,000 was difficult to identify separately within the Staff Survey, but staff satisfaction for unqualified nurses (who made up a large section of that group) was broadly unchanged at 3.48 out of 5.00 in comparison to 3.49 in 2009.
- 5.22 The **SGHSCD** commented that the 2010 Staff Survey in Scotland showed that more staff felt well informed, appropriately trained and demonstrated higher levels of employee engagement than the previous survey. Due to initiatives such as *Working Well* and putting into practice the Knowledge and Skills Framework in Scotland, the SGHSCD had promoted an atmosphere where staff were encouraged to be healthy, motivated and engaged.

Staff Bodies

- 5.23 The **Staff Side** pointed to individual staff organisations' surveys which showed that morale was falling year-on-year as staff reported increased workloads. The need for NHS services was expanding and staff faced greater pressures and higher workloads, and therefore respondents to surveys reported that their morale and motivation was falling. The Staff Side concluded that a variety of surveys carried out by staff organisations, the Department of Health and other organisations described a pessimistic picture with many staff fearing for the quality of patient care.
- 5.24 The Staff Side noted that NHS staff were feeling under pressure from the impact of high inflation and pay freezes. The Staff Side considered that this pressure was being intensified by worries about pension reforms, job security and organisational restructuring. The Staff Side highlighted that the NHS Staff Survey revealed that NHS staff remained dedicated as ever to their work, with 89% stating that they were proud to work for the NHS. However, the lowest levels of pride were among the groups that had perceived the greatest decline in the quality of patient care and the Staff Side suggested a dwindling of the dedication that the NHS relied upon.
- 5.25 The Staff Side considered that the main factors that kept staff attached to the NHS, such as commitment to their job, enjoyment of their job and the pension scheme, had all weakened in the estimation of staff. They considered that NHS staff attitudes to working in the NHS were being shaken by the pay freeze, pension reforms, the impact of budget constraints and organisational restructuring – and the long term effect of these factors had yet to be felt.

- 5.26 The staff organisations also summarised the results from their own staff surveys of their members. There were indicators from the staff organisations' surveys that the pay freeze and changes in the NHS could have significant bearing on degrees of NHS staff morale and motivation. The evidence is available from the staff organisations' websites (see Appendix E).
- 5.27 The Staff Side reported that NHS staff felt that the response of employers to the reduction in their financial settlement from the Government was to seek further cuts to the value of pay, proposing (in late 2010) an increment freeze for two years in return for a guarantee to minimise redundancies. Staff did not believe that employers would either enforce the "job guarantee" or to unfreeze pay after two years. The Staff Side stated that this proposal had caused a level of mistrust between employers and staff – employers felt aggrieved that their proposal was rejected and staff felt embittered that the proposal was made in the first place. The proposal had been a factor in staff believing that employers were targeting areas of their terms and conditions as a cost saving measure. The Staff Side reported that this fear had been heightened by a small number of foundation trust employers imposing local changes to AfC, outside of the existing flexibilities within the AfC Agreement.
- 5.28 The Staff Side commented that stress had contributed toward a disturbing picture of morale across the NHS and had played its part regarding sickness absence rates. Over the course of 2010 and 2011, sickness absence rose substantially from a three-month average of 3.9% to 4.5% by the end of 2010, before falling away slightly in 2011.
- 5.29 The results from the **RCN** members' survey in 2011 showed a marked decline in morale and motivation among the NHS nursing workforce. The RCN concluded that these results reflected heightened fears about job security, pension reforms and pay freezes. Fewer respondents felt enthusiastic in relation to their jobs – 70% compared with 80% in 2009 and fewer respondents said that nursing was a rewarding career – 72% compared with 81% in 2009.
- 5.30 The **RCM** stated that morale and motivation was low among midwives and maternity support workers caused by an increasing workload in understaffed maternity units. The potential for individuals to progress in their career was limited due to the reduction in posts and the limits put on training.
- 5.31 A survey conducted by the **Society of Radiographers (SoR)** studied modifications to sickness absence policies, demonstrating their negative effect on staff morale. Carried out in imaging and radiography departments, the survey found that NHS organisations were introducing absence monitoring schemes which could lead to withholding of sick pay, formal interviews, disciplinary proceedings and on occasion dismissals. These changes, driven by the demand to achieve savings, were leading to a worsening of staff morale, with around two-thirds of departments responding that adjustments to policies had a negative impact on morale.
- 5.32 **UNISON** considered that the morale of staff in the NHS was at its lowest ebb for a very long time. UNISON concluded that the quality of working life was declining, with rising demands in the workplace that had to be delivered with frozen or reduced resources, while real pay was falling.
- 5.33 **Unite** stated that excessive workloads were detrimental to staff morale, motivation and health and this inevitably had a negative, knock-on consequence on the quality of service delivered to patients.

Our Comment

- 5.34 From the evidence we received for this report it is clear that morale and motivation across the NHS workforce is threatened by a variety of factors. These factors are largely driven, on the one hand, by local pressures stemming from budgetary constraints, service reconfigurations, rising workload, vacancy freezes, and job security; and on the other hand, from national developments such as the NHS reforms in England, the four Governments' public sector pay policies, and proposed changes to public sector pensions.
- 5.35 We note that the NHS Staff Survey provided by the Department of Health provided a more positive conclusion on staff morale and motivation but these views were sought between September and December 2010. In contrast, the Staff Side attached a high priority to maintaining morale and motivation and highlighted worrying trends in individual union surveys regarding their decline in the NHS workforce. They could present significant challenges to employers in meeting demand for quality services and delivering on the wide-ranging change agenda, plus they could threaten longer term recruitment and retention.
- 5.36 In this respect, we consider staff engagement by employers to be an essential component of maintaining staff morale and motivation. The importance of engagement was raised several times when we met AfC staff during our 2011 visits. We observed some good examples of management practice which engaged staff to make effective changes. We encourage employers to give priority to staff engagement on a range of current issues so that staff can see that their contribution is valued thereby improving morale and motivation.

Workforce Planning

- 5.37 We commented in our Twenty-Fifth Report⁴ that it was important that wider NHS reforms were not allowed to fragment the way in which information on workforce requirements was gathered at a local level leading to imbalances between supply and demand. The parties provided further information on this issue.

Information from the Parties

The Health Departments

- 5.38 The **Department of Health** told us that, under the reforms for England, the UK Government's vision was for a provider-led workforce planning, education and training system in which the professions would have a leading role and would work with employers to ensure a multi-disciplinary approach. Following consultation on its proposals, the Department commented that the new framework would see healthcare providers, with their clinical leadership, taking a lead role in planning and developing their workforce.
- 5.39 The Department considered the new system would: provide security of supply; be responsive to patient need and changing service models; deliver continuous improvement in the quality of education and training; and ensure value for money. The Department added that effective workforce planning was key to delivering the right workforce to deliver the UK Government's vision. It considered that information and analysis from the Centre for Workforce Intelligence (CfWI) would support NHS organisations in their workforce planning and assist them in taking a long range approach to improving skills and resources.

⁴ NHSPRB (2011) *Twenty-Fifth Report*, TSO (Cm 8029), paragraph 5.27.

- 5.40 The Centre for Workforce Intelligence was set up in January 2010 to focus on three strategic areas: workforce intelligence to the health and social care system; leadership within that system; and support to the NHS, the supply of relevant resources and identifying best practice in improving the effectiveness of workforce planning at local, regional and national levels. The CfWI would publish its first report on the non-medical workforce in March 2012 analysing short term output from training and comparing its supply forecasts with estimated levels of demand and then modelling longer term demand for non-medical staff.
- 5.41 The **SGHSCD** described its *Six Steps Methodology to Integrated Workforce Planning* in NHSScotland. It added that work was continuing on Nursing and Midwifery Workload and Workforce Planning Tools and that similar work was being undertaken for the allied health professions and the health care science professions.
- 5.42 The **WG** commented that its five-year vision included three strategic workforce priorities: a rebalanced workforce; an affordable workforce; and workforce sustainability. As part of this strategy, the WG anticipated a change in the overall staff profile across AfC bands as multi-professional team working increased. The WG considered there were too many staff in Bands 2, 5 and 6 and too few in Bands 3 and 4.
- 5.43 The **DHSSPSNI** reported that the workforce planning cycle comprised a major review of each profession separately approximately every three years. The methodology for workforce reviews had been altered with more onus placed on trusts which were now required to undertake organisational level workforce planning, integrating financial, service development and workforce planning streams to help better inform the regional workforce planning process.

Staff Bodies

- 5.44 The **Staff Side** noted that the CfWI had not yet produced detailed forecasts of supply and demand. However, they highlighted the CfWI paper⁵ on the nursing and midwifery workforce which pointed to the collapse of international admissions to nursing and the rising migration of UK nurses which was now five times higher than inflow.
- 5.45 The **Royal College of Nursing** commented that current proposals for workforce planning would lead to an undersupply of nursing staff in the near future. It pointed to the *RCN Labour Market Review 2011* which suggested that previous experience of locally-led workforce planning in the 1990s, during cost containment pressures in the NHS, showed that local employers often took a narrow, local view of their future requirements.
- 5.46 **UNISON** added that there was a lack of sustained planning in relation to the upskilling of the support staff within healthcare occupations.

Our Comment

- 5.47 We are grateful to the Department of Health for further information on the process for workforce planning under the NHS reforms in England. We welcome the new role of the Centre for Workforce Intelligence to support the effectiveness of workforce planning at local, regional and national levels and note the Centre's initial reports.
- 5.48 With the planned demise of Strategic Health Authorities in England, we note the Department's intention to see local healthcare providers, under local clinical leadership, taking the lead role in planning their workforce. We are concerned whether these local healthcare providers can give sufficient priority to, and have the capacity and capability to, deliver effective local workforce planning. If they do not, the workforce

⁵ Centre for Workforce Intelligence (July 2011), *Nursing and Midwifery Workforce Risks and Opportunities* – Dunkley I and Haider S.

planning process could become fragmented and too localised. This has the potential to lead to imbalances in supply and demand for non-medical staff, including training commissions, which would lead to the future need for effective and timely responses to recruit and retain staff. Such required responses can include expensive pay solutions. This is particularly important to us over the longer term given our remit to look at market-facing pay in 2012. We ask the parties to keep us informed of progress and any emerging concerns.

Training and Development

5.49 We note that the Department of Health set out its new education and training system⁶, under the NHS reforms in England, building on responses to the consultation and the advice of the Future Forum. This included details on the role of Health Education England (HEE) and the Local Education and Training Boards. The Department announced that HEE will provide oversight and national leadership for education and training and will be expected to demonstrate how investment in education and training reflects the strategic commissioning intentions of the NHS Commissioning Board. An Education and Training Outcomes Framework will support the delivery of clinical and public health outcomes.

Health Departments

5.50 The **Department of Health's** longstanding policy was to work closely with the professions and other key partners to ensure that the non-medical workforce was appropriately trained and had access to realistic and achievable career pathways. The focus for the workforce at AfC Pay Bands 1-4 was on improving training and development as a means of empowering and enabling talented and motivated staff to progress.

Staff Side

5.51 Members' surveys undertaken by staff organisations were reported by the **Staff Side** which concluded there were worrying findings regarding NHS staff not receiving mandatory training.

Our Comment

5.52 We noted in our Twenty-Fifth Report the risks to training and development provision of devolving planning functions to local organisations in England. While the oversight by Health Education England is to be welcomed, we remain concerned about the accountability and responsibility for education and training provision as they become localised thereby, in our view, risking the appropriate level of investment and activity. Maintaining training and development will be an important contribution to service reconfigurations and achieving the appropriate skill mix. We ask that the parties keep us informed of progress when the new local arrangements are underway.

Professional Registration Fees

5.53 We note **Unite's** concerns that the costs of professional registration fees should be borne by the employer as professional registration is mandatory for many staff. **NHSE** told us that the contribution to these costs had ended as, in the employers' view, it could not be justified on cost grounds. We consider this to be a matter for the NHS Staff Council.

⁶ Department of Health (January 2012) *Liberating the NHS: Developing the Healthcare Workforce – From Design to Delivery*.

Knowledge and Skills Framework (KSF)

5.54 We noted in our Twenty-Fifth Report⁷ that KSF is an integral part of the Agenda for Change structure. We expressed concern at the low level of staff appraisals being carried out and that the level needs to be significantly higher to ensure KSF plays its intended role within the Agenda for Change structure. In that report, we also noted that the Department and NHS Employers commissioned an independent review of KSF's structure by the Institute for Employment Studies in 2010. The recommendations included:

- The need for a stronger link between KSF and staff appraisals;
- Simplification to allow greater flexibility and to meet local needs; and
- The need for better support for NHS organisations in delivering KSF at local levels.

Information from the Parties

The Health Departments

5.55 The **Department of Health** informed us that, following review, a new simplified version of the KSF had been launched which was hoped would increase appraisal completion rates. It added that a range of tools were available via the NHS Employers' website to help support trusts in increasing compliance.

5.56 The **WG** reported that the Welsh Partnership Forum had set up a Task Group to review and refine use of the revised KSF to help support the staff performance and development review process and to drive implementation across NHS Wales.

5.57 The **DHSSPSNI** reiterated that, while it did not consider the KSF to be mandatory in Northern Ireland, Health and Social Care organisations (HSC) were continuing to implement the Framework in line with the national agreement and a regional group met regularly to share knowledge, good practice and monitor progress. The NHS Staff Council had endorsed new simplified guidance on KSF and employers in Northern Ireland had welcomed this development. Progress across HSC organisations was variable ranging from 45% cover to over 99% for KSF outlines and 38% of the current workforce with a completed Personal Development Review.

5.58 **SGHSCD** told us that implementation of the KSF in Scotland had progressed very well. At a national level 85% of staff had development reviews and PDPs completed and recorded on the electronic online tool which supports the KSF process by 31 March 2011. The 2010 NHS Staff Survey in Scotland reported a majority of staff as having meetings with their managers in the last 12 months to appraise their performance and agree a personal development plan or equivalent. The SGHSCD expected that having the KSF and eKSF fully implemented would improve staff engagement, competence and job satisfaction which would in turn lead to increased recruitment and retention.

NHS Employers

5.59 **NHSE** informed us that the simplified guidance relating to the KSF had been broadly welcomed by employers across the service. The NHS Staff Survey results showed a continuing improvement in the percentage of staff who had an appraisal in the last 12 months – an increase of 8% to 77% of staff in 2010.

⁷ NHSPRB (2011), *Twenty-Fifth Report*, TSO (Cm 8029), paragraphs 5.30 - 5.39.

Staff Bodies

- 5.60 The **Staff Side** saw the process of the KSF and appraisals as the key driver in ensuring all staff were provided with personal development, access to appropriate training and line management support. However, the most recent NHS Staff Survey for England (2010) showed only a third (34%) of all staff in England felt that their review was “well structured” in that it improved how they worked, set clear objectives and left them feeling their work was valued.
- 5.61 The Staff Side hoped that the simplified KSF guidance would help to accelerate what they considered to be slow progress so that full implementation could be achieved and the benefits of the KSF could be properly realised.
- 5.62 While NHS Wales has adopted a series of measures to help achieve full implementation including improvements in monitoring, the Staff Side noted that results for 2010/11 indicated a downward trend in the level of appraisals/performance development reviews. The Staff Side observed that NHSScotland continued to progress towards full implementation of the KSF but that there was no appointed project lead with responsibility for promoting the KSF across Northern Ireland and monitoring statistics were not currently available.
- 5.63 **UNISON** pointed out that the simplified KSF guidance did not undermine or contradict the original KSF principles, and organisations could decide whether they wished to make use of the simplified guidance or continue to use the fuller version in the original KSF handbook.

Our Comment

- 5.64 We note that new, simplified KSF guidance is now available and has been generally welcomed by employers. We are also encouraged that appraisal rates have increased for AfC staff, according to the 2010 NHS Staff Survey. However, this still only covers 77% of staff and does not necessarily mean that all appraisals are linked to the KSF. Our 2011 visits demonstrated to us that use of the KSF remains patchy and it is not as widely used as it should be. However, where fully implemented, the KSF yielded positive outcomes for management and staff. We continue to emphasise that the KSF is an integral part of the AfC structure which is intended to link an individual’s pay and career progression to their acquisition and demonstration of key job competences. Where used effectively the KSF both enables checks to be applied to incremental progression to the top of pay bands and contributes to the identification of key training and development needs, to skills development and role redesign, to the delivery of safe and efficient patient services, and to staff morale and motivation.

Data Relating to Our Remit Group

- 5.65 As we have noted previously, the availability of robust, timely data on our remit group is critical to our ability to make informed, evidence-based decisions on pay and other matters. A consequence of our remits during 2012 is that the parties and ourselves will require workforce data for England in more detail than the national- or regional-level statistics currently provide.
- 5.66 Recent developments concerning workforce data produced by the Health Departments include:
- In Scotland from June 2011, the publication of quarterly statistics on the size of the workforce, vacancies and turnover;

- Development of a pay bill model for England utilising data from the Electronic Staff Record (ESR) system, which will produce more detailed and timely data on, amongst other things, pay drift for our remit group;
- In England, the Department of Health has consulted on the findings of its Fundamental Review of Data Returns⁸. The review recommended that some workforce data collections should be discontinued, and of these, some would be or have already been superseded by using data from the ESR system. The annual NHS vacancy survey was recommended to be discontinued on the condition that the information is obtained on an automated basis from the NHS Jobs website; the survey was suspended in 2011 pending the outcome of the review. Our secretariat has responded to the consultation on our behalf.

Our Comment

5.67 We are concerned about the decision to suspend the vacancy survey in England in 2011, which has made it more difficult to keep in touch with the recruitment and retention of our remit group during the period of the UK Government's public sector pay policy. In our view, there are risks concerning whether the alternative data from the new NHS Jobs website will be available for the autumn 2012 evidence; the first set of useable data may only be available for the autumn 2013 review, meaning a gap of three years in the availability of vacancy data in England. The recommendation to discontinue this collection, if accepted, will have an adverse effect on the breadth of the evidence base available to us. The absence of these data risks undermining our pay recommendations and we therefore strongly disagree with the Department of Health's recommendation to discontinue this collection in the absence of a robust replacement. On a general note, the availability and consistency of workforce data will become increasingly important in our future remits not least that for market-facing pay for AfC staff.

⁸ Department of Health (2011) *Fundamental Review of Data Returns: A Consultation on the Recommendations of the Review*. Available at: www.dh.gov.uk/en/Consultations/Liveconsultations/DH_129725.

Chapter 6 – A Forward Look

- 6.1 In this chapter, we consider briefly a range of issues raised in evidence for this report that are relevant to our future work. These centre on the four Governments' public sector pay policies, flexibilities under the AfC Agreement, developments in public sector pensions, promoting staff engagement during this period of significant change, and our data and evidence requirements.

Remits During 2012

- 6.2 We were given advance notice of our forthcoming remits in the Chancellor's Autumn Statement¹ on 29 November 2011. On 7 December 2011, the Chancellor wrote² to all Pay Review Body Chairs setting out the UK Government's view on their critical role in the years ahead.
- 6.3 The UK Government told us that: it was concerned to ensure that overall public sector pay systems were the most appropriate for the modern labour market; there was substantial evidence that the differential between public and private sector wages varied considerably between local labour markets; and that there was a clear case for ensuring that public sector pay did not distort local markets. The UK Government therefore asked us to consider how to make pay more market-facing in local areas for NHS AfC staff taking into account a range of factors. The Secretary of State for Health also wrote³ to the NHSPRB Chair on 23 December 2011 setting out the remit to take into account specific factors regarding market-facing pay for AfC staff and asking us to submit our initial findings by 17 July 2012 so that it would be possible for these to be fed into the next pay round.
- 6.4 The Chancellor also told us that the public sector pay freeze will end after 2012/13 but that, in order to support fiscal consolidation, for each of the following two years the UK Government will seek public sector pay awards that average 1%. We expect the Secretary of State for Health to write to us in advance of our next pay round providing further detail.
- 6.5 We will apply our independent process under our standing terms of reference to these remits during 2012, including taking evidence from the parties. We look forward to hearing the views of the Staff Side and individual unions who have not yet had the opportunity to respond.

Public Sector Pay Freeze

- 6.6 NHS staff have experienced a series of pressures, not least the pay freeze, and, against this background, we acknowledge the important role played by the NHS non-medical workforce in meeting service demands during a period of significant change. Such demands and pressures will naturally lead staff to look closely at the value of their pay and relative pay increases for other employees across the economy. This report was prepared under the constrained remit of the four Governments' pay policies. We note that the freeze has applied across the public sector workforce and, to a lesser or greater extent, affected staff at all levels. While we note the Staff Side's concerns about the effect of the pay freeze particularly in comparison to inflation, the impact has been across the public sector as a whole not just for staff in the NHS.

¹ Available at: http://cdn.hm-treasury.gov.uk/autumn_statement.pdf.

² Available at: http://www.hm-treasury.gov.uk/tax_pay_index.htm.

³ Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_132284.

- 6.7 The Staff Side raised a range of areas in written evidence relating to the impact of pay restraint on the NHS workforce, the value of national pay determination (as set out in a supporting research paper⁴), the UK-wide application of Agenda for Change and the impact of health policy reforms on pay determination. These all relate to our remits during 2012 on which we have called for specific evidence.

AfC Flexibilities

- 6.8 NHS Employers and the Staff Side provided information on areas under development within the NHS Staff Council. We have reported on these in the relevant sections of this report. In addition, NHSE and the Staff Side kept us informed of negotiations under the Staff Council relating to flexibilities within the AfC Agreement on pay and conditions. These negotiations will form an important backdrop to our deliberations on market-facing pay during 2012 and we therefore ask the parties to keep us up to date with progress.

Public Sector Pensions

- 6.9 We comment in Chapter 1 on developments in public sector pensions. The NHS Pension Scheme is an important part of the “total reward package” available to NHS staff. Its importance to staff was highlighted in the Staff Side evidence and reflected in the Trades Union Congress’s day of action in November 2011. Significant change is proposed in the coming years including increases to employee contributions from 2012 and potential changes to the pension structure from 2015.
- 6.10 It will be important to monitor how these changes influence membership of the NHS Pension Scheme. In this respect, the Department of Health provided us with data at September 2010 on members of the NHS Pension Scheme as a proportion of staff in each AfC pay band. We note from this data that 86% of all non-medical staff (by headcount) were estimated to be members of the pension scheme – a slight reduction on September 2009. Membership rates tended to increase with AfC pay band with the lowest proportion in Band 1 (64%), within which membership rates were also around 50% for those under 25 years old, or aged 60-64. Membership rates for the 45-49 age group were consistently higher than average. The membership rate was lowest among unqualified nurses, healthcare assistants and support staff (77%).
- 6.11 Within the “total reward package”, the value of the NHS pension is an important element which can substantially influence recruitment, retention and motivation of staff. It is therefore important that the impact of pension changes on AfC staff are assessed particularly whether it remains attractive to recruit staff and maintain retention. Specifically, under our market-facing local pay remit for 2012 we have been asked to take into account the difference in “total reward” between the NHS workforce and those of similar skills working in the private sector by location. We will therefore be calling for the parties’ views and evidence on these issues.

Staff Engagement

- 6.12 We commented in Chapter 5 on the importance of staff engagement supporting morale and motivation. The ongoing changes in the NHS present further risks to staff morale which have the potential to threaten quality patient care. We would find it helpful to receive further evidence on the prioritisation and effectiveness of staff engagement and its effect on morale as change rolls out across the NHS.

⁴ *National Pay Determination in the NHS: Resilience and Continuity* – Ian Kessler, Reader in Employment Relations at the Said Business School and Fellow at Green Templeton College, University of Oxford.

Data and Evidence Requirements

6.13 Finally, throughout this report we have emphasised that our deliberations depend on robust and timely data and information. This is essential to enable us to assess recruitment and retention trends over the longer term including monitoring any emerging shortage groups. We also need to assess accurately where pay might be part of the solution rather than wider considerations influencing recruitment (such as training commissions and available training places) and retention factors (such as workload and working patterns). Robust workforce and pay data will also be required to support our forthcoming remits during 2012.

Conclusion

6.14 We have commented throughout this report on the constraints placed on our annual remit by the four Governments' public sector pay policies. In this context, we remain concerned that these constraints do not allow us to consider the full range of evidence and issues. We believe that the Review Body process adds most value when it is able to bring independent and expert judgment to bear on all factors within our terms of reference – including the four Governments' economic and affordability evidence – while maintaining the trust of all parties to do so. Our terms of reference already allow the Governments to ask us to consider any other specific issues. The ability to make independent judgments ensures that we maintain the confidence of NHS Employers and the Staff Side in the process.

APPENDIX A – REMIT LETTERS



HM Treasury, 1 Horse Guards Road, London, SW1A 2HQ

Prof Alasdair Smith, AFPRB Chair

Ron Amy OBE, DDRB Chair

Jerry Cope, NHSPRB Chair

Dr Peter Knight CBE, PSPRB Chair

STRB Chair

Bill Cockburn CBE, SSRB Chair

20 June 2011

Dear Alasdair, Ron, Jerry, Peter, Bill and Chair

PUBLIC SECTOR PAY 2012-13

I would like to thank the Review Bodies for your work on the 2011-12 pay round. The Government greatly values the independent and expert view that the Review Bodies provide.

2. Given that we remain in the exceptional circumstance of a cross-public sector pay freeze, I am now writing – as I did last year - to set out how the Government proposes that the Review Bodies should approach the 2012-13 round. As you know, at the June 2010 Budget, the Government announced a two-year pay freeze from 2011-12 for public sector workforces where the



Government is responsible for setting pay, except for those earning a full-time equivalent of £21,000 or less, where the Government announced it would seek increases of at least £250 per year.

3. The Government believes that the case for pay restraint across the public sector remains strong. Detailed evidence will be set out in the Round, but at the highest level, reasons for this include:

- Recruitment and retention: While recognising some variation between remit groups, the evidence so far is that, given the current labour market position, there are unlikely to be significant recruitment and retention issues for the majority of public sector workforces over the next year.
- Affordability: Pay restraint remains a crucial part of the consolidation plans that will help to put the UK back onto the path of fiscal sustainability – and continued restraint in relation to public sector pay will help to protect jobs in the public sector and support the quality of public services.

4. The Government therefore remains of the view that the 2012-13 pay round should proceed in line with the approach agreed for 2011-12 – with the Review Bodies making recommendations in relation to those earning £21,000 or less. Further details on the practicalities for this round are set out in the Annex to this note.

5. As you will be aware, Lord Hutton published his final independent report on the future of public service pensions, on 10 March 2011 and the Government has accepted Lord Hutton's recommendations for reform of public service pensions as a basis for consultation with public sector workers, trades unions and others. One of these recommendations was that the Government should



make clear to Review Bodies that they should consider how public service pensions affect total reward. The Government will return to this issue as part of the overall response to Lord Hutton's report, in advance of the 2013-14 round.

6. However, independent research by the IFS in February suggested that, overall, there remains a public sector pay premium over the private sector, adjusting for the relevant skills and experience – and Lord Hutton concluded that these remain significantly more generous than private sector pensions, on average. Given this evidence, the Government is clear that any changes to pensions, including the proposed increase in contributions from 2012-13, do not justify upwards pressure on pay.

7. I found our meeting last year very helpful, so I would be delighted to meet you to discuss the issues set out above, review developments since last year and consider any specific matters that you wish to raise.

A handwritten signature in black ink, appearing to read 'Danny Alexander'.

DANNY ALEXANDER

Pay round in 2012-13

Overall approach

For the second year of the freeze - the 2012-13 pay round - the pay review body process should proceed as in 2011-12, with the exception of the School Teachers Review Body, where I recognise that a two year recommendation has been made and therefore do not expect an additional remit on this matter. Specifically:

- For those groups of workers paid above £21,000, the Government will not submit evidence or seek recommendations on pay uplifts. It will however, provide information about recruitment, retention and other aspects of the affected workforces as appropriate. The Government may ask the Review bodies to consider specific issues, other than a general pay uplift that lie within their terms of reference; and
- For those groups of workers paid £21,000 or less, the Government will look to the Pay Review Bodies to provide recommendations on uplifts. The Government will submit evidence for these groups in the Autumn in the usual way, covering the usual factors, ensuring that it is in line with the policy on pay announced at June 2010 Budget.

Because of the varied positions of the Review Body remit groups, officials will again discuss in more detail with the Review Body secretariats, and where appropriate with the Devolved Administrations, before the relevant Secretary of State writes to Review Bodies about their remit, if any, for 2012-13.

Treatment of Employees earning £21,000 or less

Definition of employees earning £21,000 or less:

- This should be determined on the basis of basic salary of a full-time equivalent employee, pro-rated on the basis of the hours worked, using the standard number of hours per week for that organisation.
- Part-time workers with an FTE salary of less than £21,000 should receive a pro-rata increase on the basis of the number of hours worked.
- The £21,000 is based on the normal interpretation of basic salary and does not include overtime or any regular payments such as London weighting, recruitment or retention premia or other allowances.

Size of Increase:

It is for the Review Bodies to recommend on the size of the uplift for those earning £21,000 or less, though the Government will seek an uplift of at least £250. When considering their recommendations, Review Bodies may want to consider:

- the level of progression pay provided to the workforce;
- affordability;
- the potential for payments to be more generous for those on the lowest earnings; and
- how best to avoid “leapfrogging” of those earning just under £21,000 with those earning just over £21,000, potentially through the use of a taper.

*From the Rt Hon Andrew Lansley CBE MP
Secretary of State for Health*



Jerry Cope
Chair
NHS Pay Review Body
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Mb-sofs@dh.gsi.gov.uk*

22 AUG 2011

Dear Jerry,

As you are aware, the Chief Secretary to the Treasury, Danny Alexander, has now written to you and the other Pay Review Body Chairs to confirm that the Government's approach to the 2012/13 pay round will be the same as to the 2011/12 round- with a pay freeze for those earning over £21,000 but the review bodies taking evidence and making recommendations in relation to those earning £21,000 or less. I am therefore writing to confirm that your remit will be the same as last year and that we will submit evidence to support this process. We will also provide evidence, as necessary, on high cost area supplements and recruitment and retention premia and information on about recruitment, retention and other aspects for those earning more than £21,000.

I am aware that the NHSPRB makes recommendations for the whole of the United Kingdom. It is for each of the devolved administrations to make their own decision on their approach to this year's Review Body round and to communicate this to you. My officials have been closely in touch, and remain closely in touch, with their counterparts in the other countries and will do all they can to support you in handling the consequences of any different approaches taken by each country.

I should like to take the opportunity to emphasise the value that I and the Government place on the independent and expert view of the Review Body. Thank you for your work. I look forward to receiving your report in due course.

I am copying this letter to Nicola Sturgeon, Edwin Poots, Lesley Griffiths and representatives of the staff side and NHS Employers.

Yours,


ANDREW LANSLEY CBE

Lesley Griffiths AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services



Llywodraeth Cymru
Welsh Government

Eich cyf/Your ref
Ein cyf/Our ref MB/LG/6255/11

Jerry Cope
Chair
NHS Pay Review Body
6th Floor, Victoria House
Southampton Row
London
WC1B 4AD

18th
September 2011

Dear Mr Cope

Following the Chief Secretary to the Treasury's confirmation of the Government's approach to the 2012/13 pay round, I am writing to confirm that the Welsh Government's stance on pay of NHS staff on Agenda for Change pay rates in Wales will be the same as for the 2011/12 pay round ie

- for those groups of workers paid above £21,000, the Welsh Government will not submit evidence or seek recommendations on pay uplifts but will provide information about recruitment, retention and other aspects of the affected workforce as appropriate
- for those groups of workers paid £21,000 or less, we will look to the NHS Pay Review Body to provide recommendations on uplifts as defined in the Annex to the Chief Secretary to the Treasury's letter of 20 June.

Recognising the role for the Review Body set out in the Agenda for Change Agreement, we will provide evidence, as necessary, on high cost area supplements and recruitment and retention premia.

I would also like to express my appreciation of the valuable contribution that the NHS PRB makes in reaching appropriate pay rates for NHS staff paid under Agenda for Change.

I am copying this letter to the Secretary of State for Health and the respective Ministers in the devolved administrations and representatives of the staff side and NHS Employers.

Yours sincerely
Lesley Griffiths
Lesley Griffiths AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Bae Caerdydd • Cardiff Bay
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Wedi'i argraffu ar bapur wedi'i ailgylchu (100%)

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FROM THE MINISTER FOR HEALTH,
SOCIAL SERVICES AND PUBLIC SAFETY
Edwin Poots MLA



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Jerry Cope
Chair
NHS Pay Review Body
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WC1B 4AD

Our Ref: SUB/1414/2011

27 September 2011

Dear Jerry

NHS Pay Review Body 2012/13

In his recent letter to you the Rt Hon Andrew Lansley CBE, Secretary of State for Health outlined his position in relation to providing evidence to the NHS Pay Review Body in the 2012/13 pay round; this is in light of the two year pay freeze. He also indicated that each of the Devolved Administrations would be writing to you separately confirming their own approach.

I can confirm that the two-year pay freeze for public sector workers announced in the emergency budget on 22 June 2010 will apply in 2012/2013 to Health and Social Care staff groups governed by the NHS Pay Review Body. We recognise that there will be an increase of at least £250 for HSC staff earning £21,000 or less subject to the Review Body process in the usual way. Northern Ireland will be providing written evidence to the NHS Pay Review Body to enable you to undertake your role in 2012/13.

I would also like to express my appreciation for the valuable contribution that the NHS PRB make in reaching appropriate pay rates for health and social care staff.



Edwin Poots MLA
Minister for Health Social Services and Public Safety

Working for a Healthier People



Deputy First Minister & Cabinet Secretary for
Health, Wellbeing and Cities Strategy
Nicola Sturgeon MSP

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30 September 2011

This letter outlines the key elements of the Scottish Government's public sector pay policy for 2012-13, announced by the Cabinet Secretary for Finance, Employment and Sustainable Growth on 21 September. Following on from that, it sets out the remit which the Scottish Government Health and Social Care Directorates would wish the NHS Pay Review Body (NHSPRB) to work to in considering evidence and making recommendations for pay in 2012-13 for staff covered by the Agenda for Change agreement.

The key features of Scotland's public sector pay policy for 2012-13 are as follows:

- Pay will be frozen (zero percent basic award) for all public sector staff for 2012-13 except those earning £21,000 and below.
- The Scottish Government recognises the importance of supporting lower paid staff within the public sector. There are therefore two specific exceptions to the freeze on basic pay.
- Continued application of the Scottish Living Wage. This is currently set at £7.15 per hour for staff doing a 37.5 hour week and will be uprated to £7.20 from 1 April 2012.
- In addition, the policy makes a commitment that all staff earning less than £21,000 should receive a minimum annual pay increase of £250.

In terms of the remit for the NHSPRB this year, therefore, we will:

- submit evidence on recruitment, retention and other issues which affect all groups of workers covered by the NHSPRB, although we will not seek recommendations on pay for staff paid over £21,000.

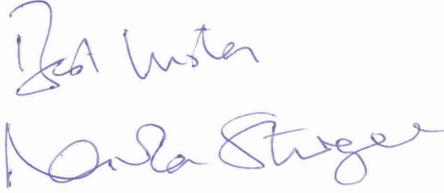
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- submit evidence for those workers currently paid £21,000 or less, and seek recommendations from the Pay Review Body on uplifts within the parameters of the Scottish Government public sector pay policy outlined above.

The enclosed evidence has been prepared in line with the remit.

Copies of this letter and accompanying evidence have been sent to the Secretary of State for Health and the respective Ministers in the devolved administrations as well as representatives of the staff side and NHS Employers.



NICOLA STURGEON

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Appendix B

Recommended Agenda For Change Pay Scales With Effect From 1 April 2012

Point	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8				Band 9
								Range A	Range B	Range C	Range D	
1	14,153	14,153										
2	14,508	14,508										
3	14,864	14,864										
4		15,279										
5		15,694										
6		16,110	16,110									
7		16,645	16,645									
8		17,253	17,253									
9			17,618									
10			18,104									
11			18,652	18,652								
12			19,077	19,077								
13				19,750								
14				20,433								
15				21,054								
16				21,176	21,176							
17				21,798	21,798							
18					22,676							
19					23,589							
20					24,554							
21					25,528	25,528						
22					26,556	26,556						
23					27,625	27,625						
24						28,470						
25						29,464						
26						30,460	30,460					
27						31,454	31,454					
28						32,573	32,573					
29						34,189	34,189					
30							35,184					
31							36,303					
32							37,545					
33							38,851	38,851				
34							40,157	40,157				
35							41,772					
36							43,388					
37							45,254	45,254				
38							46,621	46,621				
39								48,983				
40								51,718				
41								54,454	54,454			
42								55,945	55,945			
43									58,431			
44									61,167			
45									65,270	65,270		
46									67,134	67,134		
47										69,932		
48										73,351		
49										77,079	77,079	
50										80,810	80,810	
51											84,688	
52											88,753	
53											93,014	
54											97,478	

Appendix C

Composition Of Our Remit Group

C1 Figures C1 to C4 show the latest data on the composition of our remit group in each UK country¹. Owing to differences in the categorisation of staff, and the timeliness of data, information is presented separately for each country. Data relate to full time equivalent (FTE) staff except where specified.

Figure C1: Composition of the NHS non-medical workforce in England, September 2010

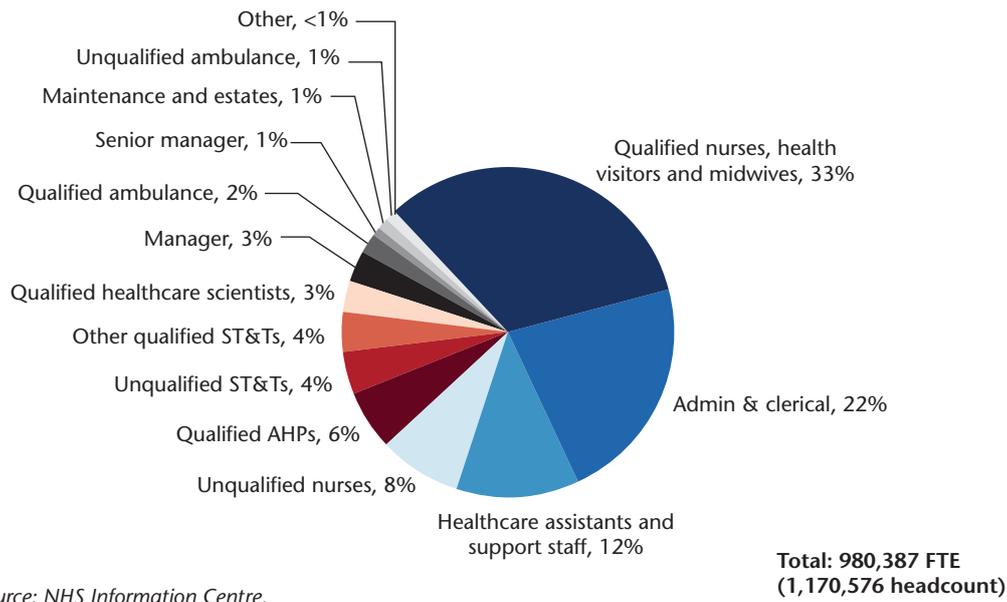
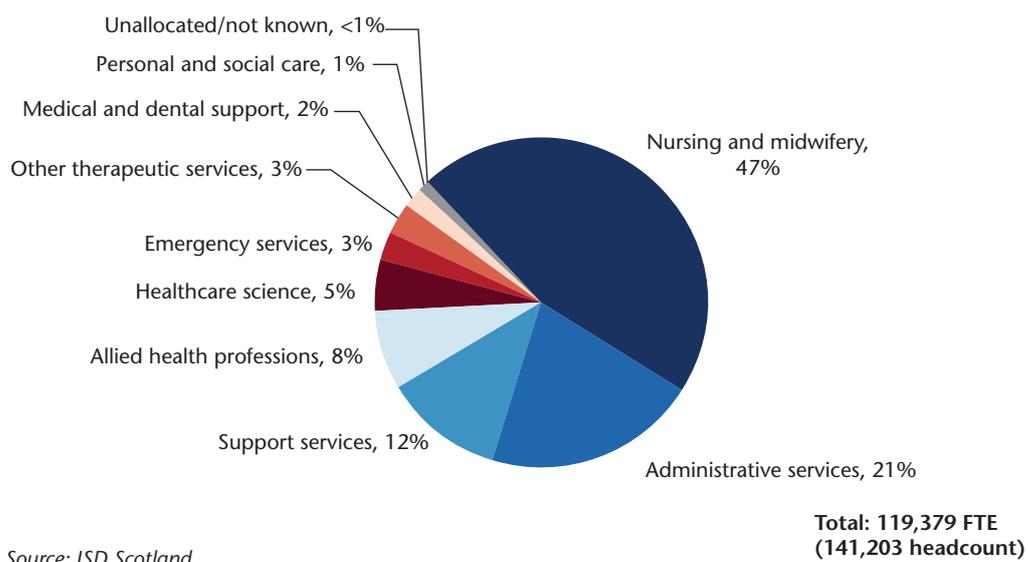
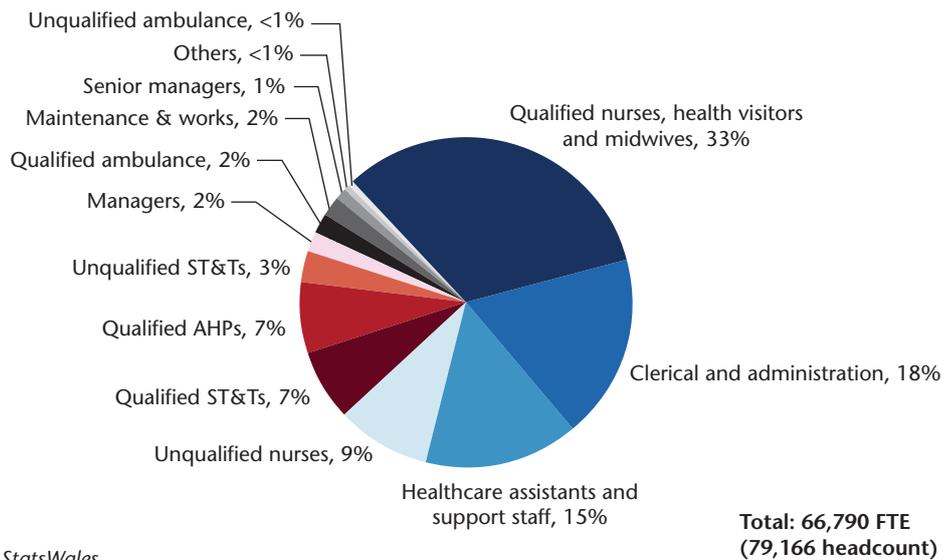


Figure C2: Composition of the NHS non-medical workforce in Scotland, September 2011



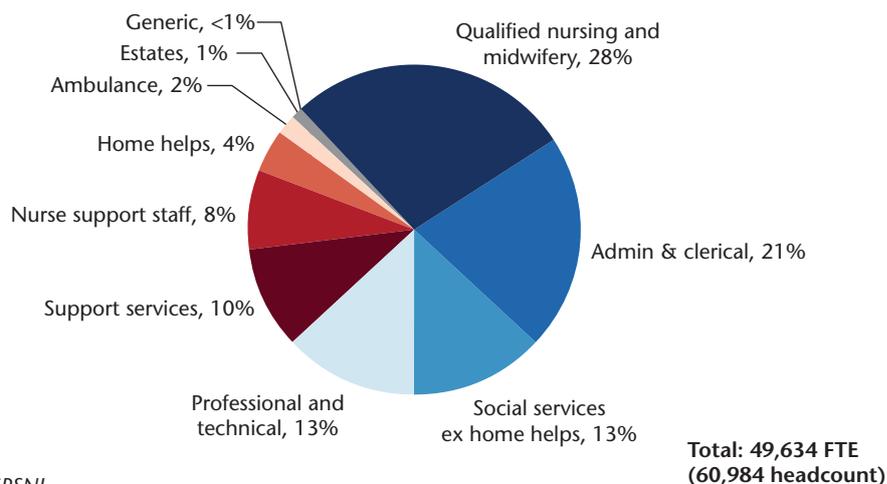
¹ Figures may not sum to 100% because of rounding.

Figure C3: Composition of the NHS non-medical workforce in Wales, September 2010



Source: StatsWales.

Figure C4: Composition of the NHS non-medical workforce in Northern Ireland, September 2011



Source: DHSSPSNI.

C2 Tables C1 to C7 show the composition of our remit group in each country and in the UK as a whole as at September 2010². Detailed categories of staff in each country have been aggregated into broad staff groups, to enable cross-UK comparisons to be made.

C3 Staff categories used in each administration’s annual workforce census have been grouped together by our secretariat. We have had to be mindful of the differences between the four datasets, and even these broad staff groups contain inconsistencies: some ancillary staff in England and Wales are categorised in the census as HCAs and support staff, but have job roles that fit better in the broad group “administration, estates and management”.

² The most recent date for which UK-wide data were available at the time of writing.

NHS Full Time Equivalent Non-Medical Workforce as at 30 September 2010

Table C1: Qualified nurses & midwives

England	FTE	Scotland	FTE	Wales	FTE	Northern Ireland	FTE	UK FTE
Qualified nurses, HVs and midwives	322,190	Nurses & midwives bands 5-9 ²	42,513	Qualified nurses, HVs and midwives	21,823	Qualified nursing & midwifery	13,775	400,300

Table C2: Nursing and healthcare assistants and support staff

England	FTE	Scotland	FTE	Wales	FTE	Northern Ireland	FTE	UK FTE
Unqualified nurses	79,178	Nurses & midwives bands 1-4 ²	15,366	Unqualified nurses	6,283	Nurse support staff	3,917	
HCA's and support staff	115,233			HCA's and support staff	10,049			
	194,411		15,366		16,332		3,917	230,025

Table C3: Professional, technical and social care

England	FTE	Scotland	FTE	Wales	FTE	Northern Ireland	FTE	UK FTE
Qualified AHPs	62,801	Medical & dental support	1,811	Qualified AHPs	4,654	Professional & technical	6,317	
Qualified healthcare scientists	29,507	AHPs	9,596	Qualified ST&Ts	4,878	Social services	6,599	
Other qualified ST&Ts	39,003	Other therapeutic services	3,407	Unqualified ST&Ts	1,951	Home helps	1,925	
Unqualified ST&Ts	39,201	Personal & social care	948					
		Healthcare science	5,628					
	170,511		21,389		11,483		14,841	218,224

³ Data in Scotland do not provide for identification of qualified staff; consequently nursing staff in Scotland on Bands 5 and above are assumed to be qualified, and staff in Bands 1-4 are assumed to be unqualified, with unbanded staff allocated pro-rata.

Table C4: Ambulance

England	FTE	Scotland	FTE	Wales	FTE	Northern Ireland	FTE	UK FTE
Qualified ambulance	17,686	Emergency services	3,698	Qualified ambulance	1,414	Ambulance	1,015	
Unqualified ambulance	7,398			Unqualified ambulance	15			
	25,083		3,698		1,429		1,015	31,225

Table C5: Administration, estates and management

England	FTE	Scotland	FTE	Wales	FTE	Northern Ireland	FTE	UK FTE
Admin & clerical	214,902	Administrative services	25,886	Clerical and admin	12,041	Admin & clerical	10,558	
Maintenance & estates	10,053	Support services	14,411	Maintenance & works	1,118	Estates services	668	
Manager	28,141			Managers	1,590	Support services	5,058	
Senior manager	11,953			Senior managers	753			
	263,411		40,297		15,502		16,283	337,131

Table C6: Other

England	FTE	Scotland	FTE	Wales	FTE	Northern Ireland	FTE	UK FTE
Others	3,144	Unallocated / not known	261	Others	221	Generic	85	3,710

Table C7: Total NHS non-medical workforce

England	FTE	Scotland	FTE	Wales	FTE	Northern Ireland	FTE	UK FTE
	980,387		123,524		66,790		49,915	1,220,616

Sources: NHS Information Centre, ISD Scotland, StatsWales, DHSSPSNI.

Appendix D

The Department Of Health's Pay Metrics

The Department of Health is currently revising the methodology that underpins the pay metrics.

There are known issues with the current methodology which will impact on the metrics and historical comparisons for recent years. These include:

- The staff group split of the pay bill is becoming increasingly unreliable due to a lack of staff group level spend data for Foundation Trusts (FTs);
- An annual snapshot of workforce numbers is used from the Census publication, rather than the average workforce over the year, which can skew per FTE pay bill and earnings calculations, and therefore per FTE growth (and drift) calculations;
- Earnings per FTE is calculated based on the pay bill per FTE and estimates of on-costs which are of uncertain reliability; and
- There are some inconsistencies introduced by the need to merge different data sources for FTs and non-FTs.

The benefits of the new approach are that it:

- Is based on more detailed and regularly available data sources;
- Uses more reliable estimates of spend across staff groups;
- Uses more detailed staff groups that are meaningful from a workforce planning perspective;
- Considers average workforce levels, as opposed to September snapshots, to give more reliable pay bill per FTE estimates;
- Provides a more detailed breakdown of pay bill across earnings and on-cost streams;
- Supports a more nuanced bottom-up approach to forecasting pay bill pressures; and
- Is available with less of a time lag and can be monitored in-year.

The Department plans to implement the new approach for the next set of metrics. In the meantime, the 2010/11 metrics have been supplied on the basis of the existing methodology.

Historical figures

The historical pay metrics (up to and including 2010/11) have been estimated using pay bill data from NHS Financial Returns, NHS Accounts and Foundation Trust Annual Reports.

Workforce statistics up to and including 2010/11 are from the annual NHS Workforce Census.

The pay bill figures include all employees of Trusts, Primary Care Trusts, Strategic Health Authorities and Foundation Trusts in England. They do not include agency staff, contractors' employees, GPs, other GP practice staff or family dentists and their staff.

The pay bill data from the Foundation Trust Annual Reports does not include a breakdown of costs by staff group; this breakdown has been estimated using historic NHS Financial Returns.

Earnings per FTE figures have been derived from the pay bill per FTE figures using the NHS Pension Scheme and National Insurance rates and thresholds that apply to NHS employers.

Note that, in years when the number of staff in higher paid staff groups has grown by more than the number in lower-paid groups, the average earnings figure for all staff has increased as a result.

Notes to the tables

1. Figures are for NHS staff in England only, and exclude Agency staff.
2. Includes estimates for the breakdown of the pay bill by staff group for Foundation Trusts (all years from 2004/05 onwards).
- 3a. Pay bill figures from 2010/11 NHS Financial Returns and Foundation Trusts Consolidated Accounts. The pay bill figures include all employees of Trusts, Primary Care Trusts, Strategic Health Authorities and Foundation Trusts in England. They do not include agency staff, contractors' employees, GPs, other GP practice staff or family dentists and their staff.
- 3b. The 2010/11 methodology has been slightly adjusted to allow for the impact of an Ambulance Trust becoming an FT in estimating the distribution of pay bill across staff groups.
4. In 2004/05, responsibility for NHS Pensions Indexation shifted from HMT to NHS employers.
5. Unqualified Nursing, HCA and Support includes Ancillary staff (e.g. cleaners and porters).
6. Scientific, Therapeutic and Technical staff (ST&T) includes Allied Health Professionals and Healthcare Scientists.
7. This total includes a small number of 'Other' staff which do not fall into any of the above staff groups (0.03% of NHSPRB workforce in 2010/11).
8. The workforce numbers are taken from published Census data which represents a snapshot as at 30th September for each given year. It must be noted that the profile of workforce growth during each year may affect the average earnings and pay bill per FTE.

Table D1: HCHS Paybill (£million)¹

	2001/02	2002/03	2003/04	2004/05 ^{2,4}	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11 ³
Qualified nursing	7,427	8,085	8,677	9,923	10,548	10,968	11,421	12,148	12,849	13,341
Unqualified nursing, HCA and support ⁵	2,512	2,740	2,946	3,406	3,731	3,757	3,890	4,062	4,494	4,507
ST&Ts ⁶	2,919	3,199	3,538	4,115	4,452	4,785	4,956	5,326	5,688	6,024
Admin & clerical	2,444	2,724	3,000	3,604	4,007	4,199	4,376	4,839	5,291	5,505
Maintenance & works	240	239	237	266	270	269	283	294	308	317
Ambulance staff	433	478	524	747	890	779	844	925	970	1,003
Managers	1,331	1,571	1,777	2,247	2,414	2,341	2,285	2,428	2,747	2,827
Total remit⁷	17,362	19,164	20,825	24,425	26,443	27,232	28,266	30,173	32,510	33,708

Table D2: Growth in HCHS Paybill¹

	2001/02	2002/03	2003/04	2004/05 ^{2,4}	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11 ³
Qualified nursing	10.9%	8.9%	7.3%	14.4%	6.3%	4.0%	4.1%	6.4%	5.8%	3.8%
Unqualified nursing, HCA and support ⁵	11.6%	9.1%	7.5%	15.6%	9.5%	0.7%	3.5%	4.4%	10.6%	0.3%
ST&Ts ⁶	11.6%	9.6%	10.6%	16.3%	8.2%	7.5%	3.6%	7.5%	6.8%	5.9%
Admin & clerical	13.1%	11.4%	10.2%	20.1%	11.2%	4.8%	4.2%	10.6%	9.3%	4.1%
Maintenance & works	2.2%	-0.8%	-0.5%	12.0%	1.5%	-0.4%	5.3%	4.0%	4.9%	2.7%
Ambulance staff	9.6%	10.2%	9.6%	42.7%	19.0%	-12.4%	8.3%	9.6%	4.9%	3.3%
Managers	12.2%	18.0%	13.2%	26.5%	7.4%	-3.0%	-2.4%	6.3%	13.1%	2.9%
Total remit⁷	11.4%	10.4%	8.7%	17.3%	8.3%	3.0%	3.8%	6.7%	7.7%	3.7%

Table D3: HCHS Paybill per FTE (£)^{1,8}

	2001/02	2002/03	2003/04	2004/05 ^{2,4}	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11 ³
Qualified nursing	27,901	28,947	29,722	32,870	34,274	35,675	37,126	38,515	39,853	41,408
Unqualified nursing, HCA and support ⁵	13,529	14,246	14,815	16,980	18,183	19,448	20,766	21,388	22,806	22,851
ST&Ts ⁶	25,214	26,028	27,210	29,864	30,998	33,022	33,580	34,326	34,567	35,329
Admin & clerical	16,258	17,132	17,473	19,659	20,919	22,583	23,862	24,913	25,134	25,617
Maintenance & works	20,449	20,164	20,682	23,545	24,687	25,619	27,870	29,126	29,661	31,509
Ambulance staff	26,559	27,983	30,006	40,117	45,360	35,896	38,876	40,012	39,648	39,974
Managers	50,650	50,806	52,567	62,418	64,289	66,800	65,368	63,998	64,622	70,510
Total remit⁷	22,456	23,547	24,334	27,444	28,851	30,288	31,650	32,577	33,439	34,382

Table D4: Growth in HCHS Paybill per FTE^{1,8}

	2001/02	2002/03	2003/04	2004/05 ^{2,4}	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11 ³
Qualified nursing	6.7%	3.7%	2.7%	10.6%	4.3%	4.1%	4.1%	3.7%	3.5%	3.9%
Unqualified nursing, HCA and support ⁵	6.9%	5.3%	4.0%	14.6%	7.1%	7.0%	6.8%	3.0%	6.6%	0.2%
ST&Ts ⁶	6.4%	3.2%	4.5%	9.8%	3.8%	6.5%	1.7%	2.2%	0.7%	2.2%
Admin & clerical	7.0%	5.4%	2.0%	12.5%	6.4%	8.0%	5.7%	4.4%	0.9%	1.9%
Maintenance & works	4.4%	-1.4%	2.6%	13.8%	4.9%	3.8%	8.8%	4.5%	1.8%	6.2%
Ambulance staff	5.8%	5.4%	7.2%	33.7%	13.1%	-20.9%	8.3%	2.9%	-0.9%	0.8%
Managers	3.5%	0.3%	3.5%	18.7%	3.0%	3.9%	-2.1%	-2.1%	1.0%	9.1%
Total remit⁷	6.5%	4.9%	3.3%	12.8%	5.1%	5.0%	4.5%	2.9%	2.6%	2.8%

Table D5: HCHS Earnings per FTE (£)^{1,8}

	2001/02	2002/03	2003/04	2004/05 ^{2,4}	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11
Qualified nursing	24,733	25,702	26,342	27,697	28,784	29,863	31,150	32,335	33,378	34,732
Unqualified nursing, HCA and support ⁵	12,256	12,899	13,394	14,563	15,528	16,532	17,670	18,211	19,367	19,440
ST&Ts ⁶	22,378	23,138	24,136	25,189	26,062	27,666	28,204	28,854	29,000	29,690
Admin & clerical	14,588	15,376	15,665	16,738	17,745	19,077	20,186	21,082	21,233	21,674
Maintenance & works	18,169	17,959	18,392	19,893	20,790	21,512	23,432	24,503	24,905	26,487
Ambulance staff	23,492	24,792	26,511	33,606	37,750	29,976	32,524	33,499	33,132	33,479
Managers	44,135	44,344	45,760	51,581	52,954	54,848	53,858	52,985	53,354	58,197
Total remit⁷	19,980	20,968	21,628	23,173	24,275	25,400	26,597	27,406	28,067	28,899

Table D6: Growth in HCHS Earnings per FTE^{1,9}

	2001/02	2002/03	2003/04	2004/05 ^{2,4}	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11
Qualified nursing	5.6%	3.9%	2.5%	5.1%	3.9%	3.8%	4.3%	3.8%	3.2%	4.1%
Unqualified nursing, HCA and support ⁵	5.6%	5.3%	3.8%	8.7%	6.6%	6.5%	6.9%	3.1%	6.3%	0.4%
ST&Ts ⁶	5.2%	3.4%	4.3%	4.4%	3.5%	6.2%	1.9%	2.3%	0.5%	2.4%
Admin & clerical	5.7%	5.4%	1.9%	6.8%	6.0%	7.5%	5.8%	4.4%	0.7%	2.1%
Maintenance & works	3.3%	-1.2%	2.4%	8.2%	4.5%	3.5%	8.9%	4.6%	1.6%	6.4%
Ambulance staff	4.7%	5.5%	6.9%	26.8%	12.3%	-20.6%	8.5%	3.0%	-1.1%	1.0%
Managers	2.6%	0.5%	3.2%	12.7%	2.7%	3.6%	-1.8%	-1.6%	0.7%	9.1%
Total remit⁷	5.3%	4.9%	3.1%	7.1%	4.8%	4.6%	4.7%	3.0%	2.4%	3.0%

Table D7: HCHS Workforce (FTE)^{1,8}

	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11
Qualified nursing	266,171	279,287	291,925	301,877	307,744	307,447	307,628	315,410	322,425	322,190
Unqualified nursing, HCA and support ⁵	185,687	192,370	198,868	200,615	205,207	193,208	187,349	189,936	197,035	197,247
ST&Ts ⁶	115,767	122,903	130,043	137,789	143,606	144,899	147,583	155,174	164,563	170,511
Admin & clerical	150,317	158,978	171,707	183,338	191,528	185,947	183,368	194,236	210,501	214,902
Maintenance & works	11,758	11,831	11,479	11,289	10,932	10,487	10,146	10,100	10,401	10,053
Ambulance staff	16,320	17,076	17,455	18,627	19,610	21,703	21,706	23,109	24,475	25,083
Managers	26,285	30,914	33,810	36,007	37,549	35,041	34,955	37,937	42,509	40,094
Total remit⁷	773,141	813,854	855,799	889,973	916,548	899,091	893,087	926,210	972,220	980,387

Table D8: Growth in HCHS Workforce (FTE)¹

	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11
Qualified nursing	3.9%	4.9%	4.5%	3.4%	1.9%	-0.1%	0.1%	2.5%	2.2%	-0.1%
Unqualified nursing, HCA and support ⁵	4.4%	3.6%	3.4%	0.9%	2.3%	-5.8%	-3.0%	1.4%	3.7%	0.1%
ST&Ts ⁶	4.9%	6.2%	5.8%	6.0%	4.2%	0.9%	1.9%	5.1%	6.1%	3.6%
Admin & clerical	5.7%	5.8%	8.0%	6.8%	4.5%	-2.9%	-1.4%	5.9%	8.4%	2.1%
Maintenance & works	-2.1%	0.6%	-3.0%	-1.6%	-3.2%	-4.1%	-3.3%	-0.5%	3.0%	-3.3%
Ambulance staff	3.6%	4.6%	2.2%	6.7%	5.3%	10.7%	0.0%	6.5%	5.9%	2.5%
Managers	8.4%	17.6%	9.4%	6.5%	4.3%	-6.7%	-0.2%	8.5%	12.1%	-5.7%
Total remit⁷	4.6%	5.3%	5.2%	4.0%	3.0%	-1.9%	-0.7%	3.7%	5.0%	0.8%

APPENDIX E

The Parties' Website Addresses

The Department of Health	http://www.dh.gov.uk/en/index.htm
The Scottish Government Health Directorates	http://home.scotland.gov.uk/home
Welsh Government	http://wales.gov.uk/?skip=1&lang=en
The Department of Health and Social Services & Public Safety in Northern Ireland	http://www.dhsspsni.gov.uk/
NHS Employers	http://www.nhsemployers.org/
NHS Staff Side (joint Staff Side)	http://www.unison.org.uk/ http://www.rcn.org.uk
British and Irish Orthoptic Society	http://www.orthoptics.org.uk/
Royal College of Midwives	http://www.rcm.org.uk/
Royal College of Nursing	http://www.rcn.org.uk
Union of Construction, Allied Trades and Technicians	https://www.ucatt.org.uk/
UNISON	http://www.unison.org.uk/
Unite	http://www.unitetheunion.org/

The parties' written evidence should be available through these websites.

APPENDIX F

Previous Reports Of The Review Body

Nursing Staff, Midwives and Health Visitors

First Report on Nursing Staff, Midwives and Health Visitors	Cmnd. 9258, June 1984
Second Report on Nursing Staff, Midwives and Health Visitors	Cmnd. 9529, June 1985
Third Report on Nursing Staff, Midwives and Health Visitors	Cmnd. 9782, May 1986
Fourth Report on Nursing Staff, Midwives and Health Visitors	Cm 129, April 1987
Fifth Report on Nursing Staff, Midwives and Health Visitors	Cm 360, April 1988
Sixth Report on Nursing Staff, Midwives and Health Visitors	Cm 577, February 1989
Supplement to Sixth Report on Nursing Staff, Midwives and Health Visitors: Nursing and Midwifery Educational Staff	Cm 737, July 1989
Seventh Report on Nursing Staff, Midwives and Health Visitors	Cm 934, February 1990
First Supplement to Seventh Report on Nursing Staff, Midwives and Health Visitors: Senior Nurses and Midwives	Cm 1165, August 1990
Second Supplement to Seventh Report on Nursing Staff, Midwives and Health Visitors: Senior Nurses and Midwives	Cm 1386, December 1990
Eighth Report on Nursing Staff, Midwives and Health Visitors	Cm 1410, January 1991
Ninth Report on Nursing Staff, Midwives and Health Visitors	Cm 1811, February 1992
Report on Senior Nurses and Midwives	Cm 1862, March 1992
Tenth Report on Nursing Staff, Midwives and Health Visitors	Cm, 2148, February 1993
Eleventh Report on Nursing Staff, Midwives and Health Visitors	Cm 2462, February 1994
Twelfth Report on Nursing Staff, Midwives and Health Visitors	Cm 2762, February 1995
Thirteenth Report on Nursing Staff, Midwives and Health Visitors	Cm 3092, February 1996
Fourteenth Report on Nursing Staff, Midwives and Health Visitors	Cm 3538, February 1997
Fifteenth Report on Nursing Staff, Midwives and Health Visitors	Cm 3832, January 1998
Sixteenth Report on Nursing Staff, Midwives and Health Visitors	Cm 4240, February 1999
Seventeenth Report on Nursing Staff, Midwives and Health Visitors	Cm 4563, January 2000
Eighteenth Report on Nursing Staff, Midwives and Health Visitors	Cm 4991, December 2000
Nineteenth Report on Nursing Staff, Midwives and Health Visitors	Cm 5345, December 2001

Professions Allied to Medicine

First Report on Professions Allied to Medicine	Cmnd. 9257, June 1984
Second Report on Professions Allied to Medicine	Cmnd. 9528, June 1985
Third Report on Professions Allied to Medicine	Cmnd. 9783, May 1986
Fourth Report on Professions Allied to Medicine	Cm 130, April 1987
Fifth Report on Professions Allied to Medicine	Cm 361, April 1988
Sixth Report on Professions Allied to Medicine	Cm 578, February 1989
Seventh Report on Professions Allied to Medicine	Cm 935, February 1990
Eighth Report on Professions Allied to Medicine	Cm 1411, January 1991
Ninth Report on Professions Allied to Medicine	Cm 1812, February 1992
Tenth Report on Professions Allied to Medicine	Cm 2149, February 1993
Eleventh Report on Professions Allied to Medicine	Cm 2463, February 1994
Twelfth Report on Professions Allied to Medicine	Cm 2763, February 1995
Thirteenth Report on Professions Allied to Medicine	Cm 3093, February 1996
Fourteenth Report on Professions Allied to Medicine	Cm 3539, February 1997
Fifteenth Report on Professions Allied to Medicine	Cm 3833, January 1998
Sixteenth Report on Professions Allied to Medicine	Cm 4241, February 1999
Seventeenth Report on Professions Allied to Medicine	Cm 4564, January 2000
Eighteenth Report on Professions Allied to Medicine	Cm 4992, December 2000
Nineteenth Report on Professions Allied to Medicine	Cm 5346, December 2001

Nursing Staff, Midwives, Health Visitors and Professions Allied to Medicine

Twentieth Report on Nursing Staff, Midwives, Health Visitors and Professions Allied to Medicine	Cm 5716, August 2003
Twenty-First Report on Nursing and Other Health Professionals	Cm 6752, March 2006
Twenty-Second Report on Nursing and Other Health Professionals	Cm 7029, March 2007

NHS Pay Review Body

Twenty-Third Report, NHS Pay Review Body 2008	Cm 7337, April 2008
Twenty-Fourth Report, NHS Pay Review Body 2009	Cm 7646, July 2009
“Consideration of Whether to Seek a Remit to Review the Pay Increase Agreed by the Parties for 2010/11”	December 2009
Twenty-Fifth Report, NHS Pay Review Body 2011	Cm 8029, March 2011

APPENDIX G

Glossary

AfC	Agenda for Change
AHPs	Allied Health Professionals
ASHE	Annual Survey of Hours and Earnings
AWE	Average Weekly Earnings
BIOS	British and Irish Orthoptic Society
CfWI	Centre for Workforce Intelligence
CPI	Consumer Prices Index
CSP	Chartered Society of Physiotherapists
Department	The Department of Health
Departments	The Health Departments
DH	Department of Health
DHSSC	Department of Health, Social Services and Children
DHSSPSNI	Department of Health, Social Services & Public Safety in Northern Ireland
EEA	European Economic Area
eKSF	Electronic Knowledge and Skills Framework
ESR	Electronic Staff Record
FTE	Full Time Equivalent
GDP	Gross Domestic Product
HCA	Healthcare Assistant
HCAS	High Cost Area Supplements
Health Departments	The Department of Health, the Scottish Government Health and Social Care Directorates, the Welsh Government and the Department of Health, Social Services and Public Safety in Northern Ireland
HEE	Health Education England
HMT	HM Treasury
HPC	Health Professions Council
HSC	Health and Social Care Organisations
HV	Health Visitor
IC	NHS Information Centre
IDS	Incomes Data Services

IES	Institute for Employment Studies
ILO	International Labour Organisation
IMF	International Monetary Fund
ISD	Information Services Division (ISD Scotland)
KSF	Knowledge and Skills Framework
LFS	Labour Force Survey
MAC	Migration Advisory Committee
NAO	National Audit Office
NHS	National Health Service
NHSE	NHS Employers
NHSPRB	NHS Pay Review Body
NOHPRB	Review Body for Nursing and Other Health Professions
OBR	Office for Budget Responsibility
OME	Office of Manpower Economics
ONS	Office for National Statistics
PCT	Primary Care Trust
PDP	Personal Development Plan
PEVS	Pharmacy Establishment and Vacancy Survey
PNC	Pay Negotiating Council
QIPP	Quality, Innovation, Productivity and Prevention
RCM	Royal College of Midwives
RCN	Royal College of Nursing
RDEL	Resource Departmental Expenditure Limit
RPI	Retail Prices Index
RRP	Recruitment and Retention Premia
SGHSCD	Scottish Government Health and Social Care Directorates
SHA	Strategic Health Authority
SOC	Standard Occupational Classification
SoR	Society of Radiographers
ST&T	Scientific, Therapeutic and Technical
TSO	The Stationary Office
TUC	Trade Union Congress
UCATT	Union of Construction, Allied Trades and Technicians

UK	United Kingdom
VAT	Value Added Tax
WG	Welsh Government



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